This is a digital copy of a book that was preserved for generations on library shelves before it was carefully scanned by Google as part of a project to make the world's books discoverable online.

It has survived long enough for the copyright to expire and the book to enter the public domain. A public domain book is one that was never subject to copyright or whose legal copyright term has expired. Whether a book is in the public domain may vary country to country. Public domain books are our gateways to the past, representing a wealth of history, culture and knowledge that's often difficult to discover.

Marks, notations and other marginalia present in the original volume will appear in this file - a reminder of this book's long journey from the publisher to a library and finally to you.

Usage guidelines

Google is proud to partner with libraries to digitize public domain materials and make them widely accessible. Public domain books belong to the public and we are merely their custodians. Nevertheless, this work is expensive, so in order to keep providing this resource, we have taken steps to prevent abuse by commercial parties, including placing technical restrictions on automated querying.

We also ask that you:

+ *Make non-commercial use of the files* We designed Google Book Search for use by individuals, and we request that you use these files for personal, non-commercial purposes.
+ *Refrain from automated querying* Do not send automated queries of any sort to Google's system: If you are conducting research on machine translation, optical character recognition or other areas where access to a large amount of text is helpful, please contact us. We encourage the use of public domain materials for these purposes and may be able to help.
+ *Maintain attribution* The Google "watermark" you see on each file is essential for informing people about this project and helping them find additional materials through Google Book Search. Please do not remove it.
+ *Keep it legal* Whatever your use, remember that you are responsible for ensuring that what you are doing is legal. Do not assume that just because we believe a book is in the public domain for users in the United States, that the work is also in the public domain for users in other countries. Whether a book is still in copyright varies from country to country, and we can't offer guidance on whether any specific use of any specific book is allowed. Please do not assume that a book's appearance in Google Book Search means it can be used in any manner anywhere in the world. Copyright infringement liability can be quite severe.

About Google Book Search

Google's mission is to organize the world's information and to make it universally accessible and useful. Google Book Search helps readers discover the world's books while helping authors and publishers reach new audiences. You can search through the full text of this book on the web at `http://books.google.com/`

Fraternally yours,
Hebert David Schenck, B.S., M.D.

TRANSACTIONS

OF THE

Homœopathic Medical Society

OF THE

STATE OF NEW YORK,

FOR THE YEAR 1907.

VOLUME LI.

EDITED BY THE SECRETARY,

H. WORTHINGTON PAIGE, M. D.,

ONEONTA, N. Y.

S. M. F.

"A homœopathic physician is one who adds to his knowledge of medicine a special knowledge of homœopathic therapeutics and observes the law of similia. ***All that pertains to the great field of medical learning is his by tradition, by inheritance, by right."*** —*President Eugene H. Porter, M. D., Feb. 1898. Amended by President John L. Moffat, Feb. 10, 1903.*

Ordered published conspicuously in the Transactions every year.—Sept. 22, 1898.

Rochester Democrat and Chronicle Print,
1907.

CONTENTS.

Officers, - - - - - - - - - - 4, 5
Fifty-Fifth Annual Meeting, - - - - - - 9
Presidential Address, by Newton M. Collins, - - - 9
Forty-First Semi-Annual Meeting, Brooklyn, - - - 159
Reports of:
Censors, - - - - - - - - - 16, 167
Treasurer, - - - - - - - - 13, 174
Committees on
Attendance, - - - - - - - - 14, 165
Legislation, - - - - - - - 19, 170
Increasing Membership, - - - - - - 18, 167
Exhibits, - - - - - - - 21, 169
Bureaus of:
Clinical Medicine and Pathology, - - - - - 33, 344
Gynæcology, - - - - - - - - 133, 399
Laryngology and Rhinology, - - - - - 150, 235
Materia Medica, - - - - - - - - 74, 246
Neurology, - - - - - - - - - 98, 322
Obstetrics, - - - - - - - - 201
Ophthalmology and Otology, - - - - - 146, 214
Pædiatrics, - - - - - - - - 64, 182
Public Health, - - - - - - - 28, 299
Surgery, - - - - - - - - - 110, 364
Appendix:
Necrologist's Report, - - - - - - - 16, 165, 425
Biographical Sketch of President Schenck, - - - 429
Constitution and By-Laws, - - - - - - 467
Standing Resolutions, - - - - - - - 471
Honorary Members, - - - - - - - 476
Chronological Table of Officers, - - - - 474
Roll of Members, - - - - - - - 476
State Directory, - - - - - - - 486
Town Index, - - - - - - - - 487
Openings for Practice, - - - - - - 490

OFFICERS, 1906-1907.

President,

NEWTON M. COLLINS, - - - - 43 East Avenue, Rochester

Vice-Presidents,

T. DRYSDALE BUCHANAN, - - - - - New York, Mhn.
FREDERICK W. SEWARD, JR., - - - - - - Goshen
ORANDO S. RITCH, - - - - - - New York, B'kn

Secretary,

H. WORTHINGTON PAIGE, - - - - - - Oneonta

Treasurer,

FREDERICK M. DEARBORN, - - 55th St. and 7th Ave., New York, Mhn.

Necrologist,

JOHN L. MOFFAT, - - - - 1136 Dean St., Brooklyn, N. Y.

Counsel,

F. E. WADHAMS, ESQ., - - - - - - Albany

CENSORS.

WM. L. LOVE,	New York, Bkn.,	(S.)	A. R. GRANT,	- - Utica,	(M.)
W. G. CRUMP,	New York, Mhn.,	(S.)	R. B. HOWLAND,	- Elmira,	(M.)
C. E. LANE,	- Poughkeepsie,	(S.)	G. H JENKINS,	- Binghamton,	(M.)
A. B. VAN LOON,	- Albany,	(E.)	S. W. HURD,	- - Lockport,	(W.)
J. I. DOWLING,	- - Albany,	(E.)	C. R. SUMNER,	- Rochester,	(W.)
J. H. HALLOCK,	Saranac Lake,	(E.)	JOSEPH RIEGER,	- Dunkirk,	(W.)

*The Censorial Districts embrace the following Counties :

SOUTHERN DISTRICT—Duchess, Kings, New York, Orange, Putman, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, Westchester—12.

EASTERN DISTRICT—Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Green, Hamilton, Herkimer, Montgomery, Otsego, Rensselaer, St. Lawrence, Saratoga, Schenectady, Schoharie, Warren, Washington—19.

MIDDLE DISTRICT—Allegany, Broome, Cattaraugus, Chemung, Chenango, Jefferson, Lewis, Livingston, Madison, Oneida, Oswego, Schuyler, Steuben, Tioga, Tompkins - 15.

WESTERN DISTRICT—Cayuga, Chautauqua, Cortland, Erie, Genesee, Monroe, Niagaga Onondaga, Ontario, Orleans, Seneca, Wayne, Wyoming, Yates—14.

OFFICERS, 1907-1908.

President,

HERBERT DANA SCHENCK, - - - 75 Halsey Street, Brooklyn

Vice-Presidents,

FRANK W. ADRIANCE, - - - - 306 Lake St., Elmira
WILLIAM A. KEEGAN, - - 40 Clinton Avenue, S , Rochester
H. D. COCHRANE, - - - - - 59 Eagle St., Albany

Secretary,

H. WORTHINGTON PAIGE, - - - - - - Oneonta

Treasurer,

REEVE B. HOWLAND, - - - - 306 Lake St., Elmira

Necrologist,

JOHN L. MOFFAT, - - - - 1136 Dean St., Brooklyn

Counsel,

FREDERICK E. WADHAMS, Esq., - - - 33 Tweedle Bldg., Albany

Censors,

CHARLES E. TEETS, New York, (S.)
DAVID J. ROBERTS, New Rochelle, (S.)
NATHANIEL H. IVES, Mt. Vernon, (S)
HOWARD P. DEADY, Liberty, (E.)
FREDERICK J. COX, - Albany, (E.)
HERBERT L. TOWNE, Schenectady, (E.)
CHARLES T. HAINES, - Utica, (M.)
CHARLES A. Ward, Binghamton, (M.)
LOUIS D. HYDE, - Owego, (M.)
FRANKLIN P. WARNER, Can'daigua, (W.)
THOMAS PARSONS, Rochester, (W.)
GEORGE T. MOSKLEY, Buffalo, (W.)

DELEGATES TO THE INTERSTATE COMMITTEE OF THE AMERICAN INSTITUTE OF HOMŒOPATHY.

W. S. GARNSEY, - - - - - - *To Serve Until 1909*
A. B. NORTON (Appointed to fill vacancy), - - *To Serve Until 1911*

COMMITTEE ON INCREASING MEMBERSHIP.

ORANDO S. RITCH, *Chairman*, - - - 337a Macon, Brooklyn
WILLIAM H. PRICE, - - - - 621 St. Marks Ave., Brooklyn
G. DE WAYNE HALLETT, - - - - 128 W. 85th, New York
ROBERT M. JONES, - - - - - 161 W. 47th, New York
NATHANIEL H. IVES, - - - - 145 Second Ave., Mt. Vernon
FRANK A. JACOBSON, - - - - - 269 Grand, Newburg
ARBA R. GREEN, - - - - - - 25 Second, Troy
GORDON W. HOYT, - - - - - 426 Warren, Syracuse
J. ELMER SNODGRASS, - - - - 20 William, Auburn
LYNN A. MARTIN, - - - - 177 Washington, Binghamton
ALBERT H. RODGERS, - - - - - - Corning
WILLIAM PERRIN, - - - - - 343 West Ave., Rochester
S. WRIGHT HURD, - - - - - - 78 Main, Lockport
JOSEPH RIEGER, - - - - - 509 Central Ave., Dunkirk
G. R. STEARNS, - - - - - 201 Linwood Ave , Buffalo

COMMITTEE ON MEDICAL LEGISLATION.

JOHN E. WILSON, *Chairman*, - - - 616 Madison Ave., New York
JOHN L. MOFFAT, - - - - - 1136 Dean St., Brooklyn
WILLIAM H KING, - - - - 616 Madison Ave., New York
IRVING TOWNSEND, - - - - - 67 W. 47th, New York
CHARLES GENNERICH, - - - - 181 E. 64th, New York
CHARLES E BIRCH, - - - - - - White Plains
FREDERICK J. COX, - - - - 99 Washington Ave., Albany
H. E. MERRIAM, - - - - - - - Owego
BRADFORD W. SHERWOOD, - - - - 1117 S. Salina, Syracuse
JOHN M. LEE, - - - - - - 179 Lake Ave., Rochester
DE WITT G. WILCOX, - - - - 597 Elmwood Ave., Buffalo
DANIEL H. ARTHUR, - - - - - - - Gowanda

COMMITTEE ON LIFE INSURANCE COMPANIES.

CHARLES T. HAINES, *Chairman*,	42-45 Gardner Bldg., Utica
PHILIP C. THOMAS,	New York
CHARLES E. LANE,	Poughkeepsie
LOUIS FAUST,	Schenectady
F. E. ROPER,	Norwich

PRESS COMMITTEE.

WILLARD C. DUBOIS, *Chairman*,	519 S. Salina, Syracuse
JOHN L. MOFATT,	Brooklyn
WALTER SANDS MILLS,	New York
JOSEPH I. DOWLING,	Albany
EDWARD G. COX,	Albany
GEORGE H. JENKINS,	Binghamton
ERMINA C. EDDY,	Elmira
LOUIS W. DEAN,	Utica
W. S. RAMBO,	Rochester
JOHN G. CHADWICK,	Buffalo

COMMITTEE ON EXHIBITS.

BERT B. CLARK, *Chairman*,	166 W. 126th St., New York
W. H. DIEFFENBACH,	New York
WALTER B. WINCHELL,	Brooklyn
HERBERT C. ALLEN,	Brooklyn
CHARLES L. BAILEY,	Albany
WILLIAM P. FAUST,	Schenectady
MARTIN BESEMER,	Ithaca
P. W. NEEFUS,	Rochester
B. J. MAYCOCK,	Buffalo

COMMITTEE ON LOCAL ARRANGEMENTS FOR SEMI-ANNUAL MEETING.

ALTON G. WARNER, *Chairman*,	19 Schermerhorn St., Brooklyn
JAMES B. GIVEN,	Brooklyn
HENRY J. PIERRON,	Brooklyn
WALTER S. RINK,	Brooklyn
ROY UPHAM,	Brooklyn

COMMITTEE ON LOCAL ARRANGEMENTS FOR ANNUAL MEETING.

ARTHUR B. VAN LOON, *Chairman*,	198 State St., Albany
WM. J. MCKOWN,	Albany
W. D. SPOOR,	Schenectady
R. F. BENSON, JR.,	Troy
A. R. GRANT,	Utica

COMMITTEE ON ENTERTAINMENT OF LADIES, SEMI-ANNUAL MEETING.

MRS. WM. W. BLACKMAN, *Chairman*,	519 Clinton Ave., Brooklyn
MRS. HERBERT D. SCHENCK,	Brooklyn
MRS. ALTON G. WARNER,	Brooklyn
MRS. WALTER B. WINCHELL,	Brooklyn
MRS. JOHN L. MOFFAT,	Brooklyn
MRS. ORANDO S. RITCH,	Brooklyn
MRS. EDWARD CHAPIN,	Brooklyn
MRS. GEORGE HILLS ILER,	Brooklyn
MRS. HENRY J. PIERRON,	Brooklyn
MRS. NATHANIEL ROBINSON,	Brooklyn
MRS. E. RODNEY FISK,	Brooklyn
MRS. HENRY B. MINTON,	Brooklyn
MRS. HERBERT C. ALLEN,	Brooklyn
MRS. RALPH I. LLOYD,	Brooklyn
MRS. GEORGE F. LAZARUS,	Brooklyn

BUREAU OF MATERIA MEDICA.

RUDOLPH F. RABE, *Chairman*,	616 Madison Ave., New York
STUART CLOSE,	Brooklyn
WILLIAM H. FREEMAN,	Brooklyn
LAWRENCE M. STANTON,	New York
E. WILTON BROWN,	Mount Kisco
CHARLES E. ALLIAUME,	Utica
EDWARD A. EVERETT,	Elmira
R. C. GRANT,	Rochester
JOSEPH T. COOK,	Buffalao

BUREAU OF CLINICAL MEDICINE AND PATHOLOGY.

HOWARD P. DEADY, *Chairman*,	Liberty
WILLIAM S. SEARLE,	Brooklyn
M. CLIFFORD PARDEE,	Brooklyn
GEORGE F. LAIDLAW,	New York
E. GUERNSEY RANKIN,	New York
STEPHEN T. BIRDSALL,	Glen Falls
L. A. FRAZIER,	Amsterdam
W. S. GARNSEY,	Gloversville
LYNN A. MARTIN,	Binghamton
E. H. NOBLE,	Elmira

BUREAU OF PUBLIC HEALTH

W. HERBERT NICKELSON, *Chairman*,	Adams
HILLS COLE,	New York
E. A. SIMONS,	Carthage
CHARLES T. HAINES,	Utica
W. ESTUS DEUEL,	Canastota
BRADFORD W. SHERWOOD,	Syracuse
W. D. HOUGH,	Niagara Falls
F. PARK LEWIS,	Buffalo

BUREAU OF SURGERY.

JOSEPH H. FOBES, *Chairman*,	222 W. 59th, New York
GEORGE HILLS ILER,	Brooklyn
GEORGE W. ROBERTS,	New York
WILLIAM F. HONAN,	New York
WILLIAM T. HELMUTH,	New York
A. R. GRANT,	Utica
J. HERBERT IRISH,	Syracuse
LUCIUS L. BUTTON,	Rochester
GEORGE T. MOSELEY,	Buffalo
With the invited co-operation of	
CHARLES E. WALTON,	Cincinnati, Ohio

BUREAU OF OBSTETRICS.

CHARLES E. BIRCH, *Chairman*,	White Plains
WILLIAM W. BLACKMAN,	Brooklyn
LOOMIS L. DANFORTH,	New York
H. S. HATHAWAY,	New York
E. P. SWIFT,	New York
R. R. TROTTER,	Yonkers
MATHEW J. HALL,	Mamaroneck
E. H. WOLCOTT,	Rochester
HERBERT DE L. KNICKERBOCKER,	Springwater

BUREAU OF PÆDIATRICS.

HORACE G. KEITH, *Chairman*,	317 S. Broadway, Yonkers
WILLIAM L LOVE,	Brooklyn
WALTER GRAY CRUMP,	New York
JOHN PERRY SEWARD,	New York
GEORGE P. HOLDEN,	Yonkers
NATHANIEL H. IVES,	Mount Vernon
ROY A. PAGE,	Geneseo
EMILY F. SWETT,	Medina

BUREAU OF NEUROLOGY.

MAURICE C. ASHLEY, *Chairman*,	Middletown
WILLIAM MORRIS BUTLER,	Brooklyn
JOHN E. WILSON,	New York
REEVE TURNER,	New York
FREDERICK W. SEWARD,	Goshen
ROBERT C. WOODMAN,	Middletown
GEORGE F BREWSTER,	Middletown
ROY E. MITCHELL,	Middletown
ARTHUR S. MOORE,	Middletown
JOHN T. GREENLEAF,	Owego
DANIEL H. ARTHUR,	Gowanda
CLARENCE A. POTTER,	Gowanda

BUREAU OF OPHTHALMOLOGY AND OTOLOGY.

GEORGE W. MCDOWELL, *Chairman*,	1 W. 34th, New York
JOHN L. MOFFAT,	Brooklyn
ALTON G. WARNER,	Brooklyn
ARTHUR B. NORTON,	New York
G. DEWAYNE HALLETT,	New York
GEORGE A. SHEPARD,	New York
CHARLES H. HELFRICH,	New York
ELMER J. BISSELL.	Rochester
HERBERT W. HOYT,	Rochester
FRED D. LEWIS,	Buffalo

BUREAU OF LARYNGOLOGY AND RHINOLOGY.

LLEWELLYN J. SANDERS, *Chairman*,	213 Alexander Ave., Rochester
RALPH I. LLOYD,	Brooklyn
CHARLES E. PAINE,	Brooklyn
ROBERT M. JONES,	New York
JOSEPH I. DOWLING,	Albany
W. H. DOANE,	Rochester
R. C. CONKLIN,	Batavia
FRANK B. SEITZ,	Buffalo

BUREAU OF GYNÆCOLOGY.

E. RODNEY FISKE, *Chairman*,	1172 Dean St., Brooklyn
HERBERT C. ALLEN,	Brooklyn
WILLIAM H. DIEFFENBACH,	New York
EDWARD G. TUTTLE.	New York
FREDERICK W. HAMLIN,	New York
SIDNEY F. WILCOX,	New York
GEORGE E. GORHAM,	Albany
JOHN M. LEE,	Rochester
SHIRLEY R. SNOW,	Rochester
DEWITT G. WILCOX,	Buffalo

PROCEEDINGS

OF THE

Fifty-Fifth Annual Meeting of the Homœopathic Medical Society of the State of New York, held in Albany, N. Y., Tuesday and Wednesday, February 12th and 13th, 1907.

The President, Dr. Newton M. Collins, called the meeting to order in the ball room of the Hotel Ten Eyck at 10:00 o'clock A. M., on February 12th, and introduced the Rev. Chas. S. Hagar, of Albany, who offered an invocation.

The President announced the appointment of the following committees:

Attendance—W. H. Doane, F. D. Lewis, H. O. Rockefeller.

Auditing—Chas. T. Haines, John L. Moffat, Hills Cole.

President's Address—Herbert D. Schenck, George E. Gorham, John W. Le Seur.

Tellers for Election of Officers (appointed February 5th)—Charles T. Haines, A. R. Grant, H. Worthington Paige.

Tellers for Election of State Medical Examiners—H. D. Cochrane, F. D. Lewis.

Secretary H. Worthington Paige submitted Volume L., year 1906, of the Transactions as distributed, as the official minutes of the past two meetings. He further urged that all matters brought before the Society—resolutions, papers, reports, etc., be presented in writing and in form for publication, and that such documents be laid at once upon the Secretary's desk.

PRESIDENTIAL ADDRESS.*

By Newton M. Collins, M. D.

Ladies and Gentlemen:

Now that the staid old city of Boston has "set the pace" by having papers read at recent meetings of the Boston Homeopathic Medical Society, by leading physicians of the dominant school, upon the similarity and interdependence of the schools, I will venture to present what seems to me a timely need in our school, viz., Liberalism in medicine.

*Delivered Tuesday evening immediately after the Annual Banquet.

The following reasons have been given at various meetings of the Society why we, as a school, are not making greater progress: Some say it is because the present homeopathic physicians do not spend the amount of time that their forefathers did in selecting the indicated remedy; others believe it is due to the fact that homeopathic physicians resort to the palliatives of the dominant school and claim that they fail to cure their patients; still others think it is because our homeopathic colleges are too liberal in their teachings, alleging that their recent graduates know very little of homeopathy, but are well versed in old-school methods.

None of these reasons appeal to me as being adequate. To begin with, the homeopathic physician of to-day is competing with an entirely different class of physicians than our forefathers did, when bleeding, salivation and excessive drugging was the therapy. To-day, the leading and most progressive physicians of the dominant school are using less and less medicine, and are more and more giving the single remedy. In fact, there are many diseases where no remedy is used, except perhaps in the incipient stage, when a cathartic or diuretic is given. They claim to have but few specifics, and some of them probably work homeopathically, as Dr. Cabot, of Harvard University, said in his paper recently read before the Boston Homeopathic Medical Society, entitled, "How Far Do Homeopathic and Other Physicians Agree, and How Far Can They Agree?" from which I quote: "We have been wrong in not admitting more candidly the bearing of certain well-known facts of pharmacology on the issue between your school and ours. The use of digitalis in relatively small doses to relieve symptoms similar to those of its overdose; the similarity between the symptoms of scarlet fever and those of belladonna poisoning; the supposed value of ipecac in controlling nausea (still stated in our textbooks, though most of us fail to obtain any such effects); the fact that you can produce some —by no means all—of the symptoms of malaria by large doses of quinine and some lesions like those of syphilis by overdosing with mercury; that nitro-glycerine will often produce, and sometimes cure, a headache; all of these are facts which we should realize and whose significance we should study as far as we can. Further: "The use of tuberculin is a form of vaccination which illustrates better than any other example known to me the approval of homeopathic principles by our school." * * * "The use of bacterial vaccines in infectious diseases recently produced by Mr. A. E. Wright, the English physician, is distinctly homeopathic." Von Behring, of antitoxin fame, attributes the efficacy of his serums to its homeopathic action.

Many other instances could be cited where physicians of the dominant school use homeopathic treatment, and now that they give credit to Homeopathy, ought we not to make a similar admission and credit them with many of the good things we are constantly using, which were "brought out" by their investigation and management of diseased conditions? Great progress has been made since

Hahnemann's time, and it is not to our discredit that *we* have not only recognized this, but have also made use of it. As soon as *we*, as a school, are honest enough to admit what we use, and the dominant school makes a similar acknowledgment, will each school be in a position to avail itself of much that is good in the other. For example, the dominant school has spent more time in diagnosis, pathology and bacteriology than we have, and we can profit from their study, if we will; while, on the other hand, there is an equally good opportunity for them to profit by giving more attention to the treatment of disease by drugs given homeopathically. I am glad to say that we have passed the age of devoting our entire attention to symptomatology, and believe that many of us are in accord with the late Professor McClatchey, when he told his class that they might better pave the street than be mere *symptom matchers*. However, I firmly believe that where medicine is indicated, and a drug has been found that has produced similar symptoms in the well, that drug will cure disease much more quickly when given by the law of similars than in any other way; but in that selection we must take cognizance of *all the collateral branches of medicine* bearing on the case. We must always remember, however, that the *first and most important factor of all is a thorough diagnosis.* While attending the Hahnemann Medical College in Philadelphia, we were sent once a week to the Pennsylvania Hospital to attend the clinics of the late Dr. Da Costa. At that time it seemed to us that he spent too much time in diagnosing his cases and too little in treatment. After one has been in actual practice for a few years, one can see that the time spent upon the diagnosis was none too great.

There are many other homeopathic remedies than those Dr. Cabot mentioned which have been proven to act equally well; and I have not the slightest doubt that in less than a decade the dominant school will be using ten drugs homeopathically where they now use one; while, on the other hand, we shall be using the best they have to offer without hesitating to acknowledge its source.

If we are to be progressive, "up-to-date" physicians, we must broaden our view of medicine, turn a receptive ear to all that is new, even though it seems foreign to the tenets of Homeopathy. If there is truth in it, it is ours because we are broad enough to appreciate it. I am proud of the straightforward men in our school who are honest enough to say that there are other agents than drugs that will cure disease. Dr. Sutherland, one of our honored guests this evening, in a most excellent paper read at the meeting of the Western New York Homeopathic Medical Society, held in Rochester last year, showed us the beneficial results of the high of metabolism. It is a known fact that there are many ways of arriving at the same end. For example, to increase the solids in the urine, the homeopath may give colchicine, apis, berberis, cuprum arsenicum, and many other remedies; the old-school physician resorts to diuretics and cathartics; the physical culturist advises systematic exercises; the osteopath stimulates the trophic nerve

centers along the spine; the hydrotherapist uses baths and enteroclysis; and the electrotherapist the high frequency current. Why should we not feel free, when occasion arises, to use these methods in our treatment? By so doing we shall be living up to the definition of a homeopathic physician, as stated by Dr. Porter some years ago: "A homeopathic physician is one who adds to his knowledge of medicine a special knowledge of therapeutics, and observes the law of similia. All that pertains to the great field of medical learning is his by tradition, by inheritance, by right."

At the last meeting of the Surgical and Gynæcological Society of the American Institute of Homeopathy, the use of morphine immediately following an operation was discussed by the surgeons present, and at least eight out of every ten agreed that it was only humane to use something to allay excessive pain. A large number admitted that it acted beneficially in lessening shock, and caused no bad after-effects. No one present, however, advised the continued use of it. One surgeon suggested that any surgeon who did not believe in a palliative after an operation, ought to have an operation himself, and he was sure he would then be converted.

Specialists are accused of being liberal in their views so that they will get more consultations with physicians of other schools. My own opinion is that liberality in the specialists *of all schools* is caused, to a great extent, by "rubbing up against" liberal men in consultation and post-graduate work; and he who accuses the specialist of being too liberal would not only benefit by this same meeting with liberal men, but would in all probability be broadened to the same extent. Men of our school in attendance upon old-school post-graduate colleges and clinics receive the same courtesies that are accorded men of their own school, and is it any wonder, then, that our specialists feel kindly toward the liberal ones of the dominant school? The fact is that when we make these criticisms, we are doing just what we condemned in the old-school many years ago. Now that they are willing and anxious to be friendly, it behooves us, as progressive physicians, to do likewise. It might be well to remember the lines so often repeated:

> "There is so much good in the worst of us,
> And so much bad in the best of us,
> That it ill behooves any one of us
> To criticise the rest of us."

We, as a school, can do no better than follow Dr. Cabot's advice. He says: "I am anxious to 'get together;' not merely with the homeopaths, but with every other group of persons who think they can cure disease, or anybody else who thinks he can help the sick. I want to find out, so far as I can, what is true in his beliefs. I believe that it is important that we look for truth wherever it is to be found, and learn whatever can be learned without prejudice and without fear that any truth we *have* already may be upset by learning more truths from any other man." * * * "Gentlemen, we want the truth, all of it that we can get hold of.

Two ships that steer for the same port are sure to come together sooner or later, no matter how far apart on the ocean. If we keep ourselves in this mind, if we are fair and honest, and not uncharitable, we shall pool our knowledge some day and abolish sectarianism in medicine. I hope and pray that this consummation may come in our lifetime. Whether or not it does, depends largely upon us, our earnestness, our honesty, and our good will."

What we need is liberality! More personal contact with members of other schools and to cast aside all those prejudices that have been handed down from the time when prejudices meant our very existence.

I wish to make a few recommendations and suggestions which, I believe, should receive our most earnest consideration. To increase the membership of our State Society, it would be well to adopt the plan of the New York State Medical Society by making membership in a county society include membership in the State Society. I would also suggest the addition of a bureau on Electro-therapeutics, as so much good work is being accomplished along this line. The question of the contract physician to the various and manifold fraternal organizations should be threshed out, and some united action be taken to suppress this evil which has been making so great progress of late. I would further recommend concerted action upon the part of this Society in having an amendment made to the present garnishee laws passed so as to include the services of physicians; also that *we use our influence* in having proper laws passed to correct the evils of *child labor*. Finally, it is my most earnest desire that the American Institute of Drug-Proving shall receive the hearty and cordial support of every member of this Society.

REPORT OF THE TREASURER.

F. M. DEARBORN, M. D., Treasurer, in account with the Homeopathic Medical Society of the State of New York.

Mr. President and Members of the Society:

I beg to submit the following report for the year commencing February 13, 1906, and ending February 12, 1907.

RECEIPTS.

Cash on hand February 12th, 1906,	$ 391 09
From Dinner Committee of Annual Meeting,	172 00
Membership fees and dues, new members,	150 00
Dues from active members,	1,162 00
Interest on balance in bank,	64
Committee on Exhibits, annual and semi-annual meetings,	376 64
Total,	$ 2,252 37

DISBURSEMENTS.

Rev. G. F. Whittemore for expenses, annual meeting,	$ 10 00
F. A. Bernard & Co., badges, annual meeting,	20 00
Albany Co. Printery, dinner tickets, annual meeting,	1 25

H. J. Rockwell & Son, dinner and room rent, annual meeting,	293 25
Rochester Printing Co., printing transactions and 100 copies proceedings of Watson Banquet,	548 69
Dr. C. T. Haines, expenses annual meeting,	23 55
A. B. Weaver, official stenographer,	84 50
Pusey & Co., Treasurer's printing,	7 50
Dr. B. B. Clark, expenses of Committee on Exhibits,	62 32
Dr. F. M. Dearborn, postage, clerks' hire,	18 20
Dr. E. F. Porter, expenses Legislative Committee,	87 00
Ames & Rollinson, certificates,	20 85
Rochester Printing Co., printing for Life Insurance Committee,	10 25
Dr. H. W. Paige, salary 1st quarter and expenses,	80 90
Oneonta Press, secretary's printing,	24 85
City Club Bureau of Legislative Information,	25 00
Dr. H. W. Paige, salary 2nd quarter and expenses,	76 30
Dr. H. W. Paige, salary 3rd quarter and expenses,	76 80
Ethel M. Terrell, Secretary's addressing,	9 46
Dr. F. M. Dearborn, stamps,	5 00
Oneonta Press, Secretary's printing,	112 50
Pusey & Co., Treasurer's printing,	9 50
Lilly & Co., badges semi-annual meeting,	23 99
A. B. Weaver, official stenographer,	79 62
Dr. N. M. Collins, expenses semi-annual meeting,	110 00
Dr. H. W. Paige, salary 4th quarter and expenses,	80 35
E. M. Terrell, Secretary's addressing,	7 66
Dr. F. M. Dearborn, stamps and clerks' hire,	15 00
Total,	$ 1,924 29
Balance on hand,	$ 328 08

All of which is respectfully submitted.

F. M. DEARBORN, *Treasurer.*

REPORT OF THE AUDITING COMMITTEE.

ALBANY, FEBRUARY 12, 1907.

Examined and found correct.

C. T. HAINES,
HILLS COLE,
JOHN L. MOFFAT,
Auditing Committee..

Report, upon motion, adopted.

REPORT OF THE COMMITTEE ON ATTENDANCE.

There were in attendance at the several sessions 85 members and 19 visitors, a total of 104. The enrollment by counties was as follows:

Albany County—Geo. E. Gorham, H. D. Cochrane, A. B. Van Loon, N. Huntington, A. A. Vibbard, F. J. Cox, B. E. Kinne, W. M. Campbell, B. E. Marshall, Wm. J. McKown, M. E. Milbank.

Broome County—L. A. Martin.

Cattaraugus County—J. D. Zwetsch.

Chemung County—R. B. Howland.

Cortland County—E. B. Nash, Chas. L. Mosher.

Erie County—D. G. Wilcox, Frederick C. Robbins, Fred D. Lewis.

Fulton County—E. H. Eisenberg.

Genesee County—John W. LeSeur.

Kings County—Orando S. Ritch, Herbert D. Schenck, Henry O. Rockefeller, John L. Moffat, Stuart Close.

Monroe County—W. H. Doane, Newton M. Collins, John M. Lee, R. C. Grant, Edwin H. Wolcott.

New York County—Reeve Turner, Hills Cole, Clarence C. Howard, F. M. Dearborn, Rudolph F. Rabe, Guy B. Stearns, D. E. S. Coleman, Geo. F. Laidlaw, J. T. Simonson, Bert B. Clark, A. W. Palmer, Bukk G. Carleton, John B. Garrison, G. W. Roberts, Geo. W. McDowell, John E. Wilson, Geo. A. Shepard, Irving Townsend, Wm. Francis Honan, Wm. H. Vanden Burg, F. E. Rabe, Chas. E. Teets.

Oneida County—W. C. Scudder, C. T. Haines, C. E. Chase, A. R. Grant, C. E. Alliaume.

Onondaga County—J. Willis Candee, Otis M. Wiley, Herbert A. Church, W. L. Hartman, J. Herbert Irish.

Orange County—M. C. Ashley, Geo. F. Brewster, Fred'k W. Seward, Jr.

Otsego County—H. Worthington Paige.

Rensselaer County—H. L. Waldo, Crawford R. Green.

Saratoga County—Osmond J. Travers.

Schenectady County—H. L. Towne, D. E. Spoor.

Tioga County—J. T. Greenleaf.

Warren County—S. T. Birdsall, C. A. Horton.

Washington County—E. T. Horton, H. L. Raymond.

Wayne County—E. P. Thatcher.

Westchester County—E. W. Brown, C. J. Miller, Horace G. Keith, Nathaniel H. Ives, R. R. Trotter, D. J. Roberts.

Wyoming County—W. B. Gifford.

Visiting Physicians—J. P. Sutherland, W. C. Goodo, Olin J. Fryer.

Visitors—Mary Hoffman Jones, H. H. Lenahan, Fourteen exhibitors.

Signed, W. H. DOANE,
F. D. LEWIS,
H. O. ROCKEFELLER,
Committee.

REPORT OF THE BOARD OF CENSORS.

The Board of Censors, represented by Drs. Reeve B. Howland and A. R. Grant, recommended the election of the following seventeen applicants for membership in the Society. The names were presented and duly elected to regular membership.

NAME AND RESIDENCE.	ENDORSERS.
HAROLD H. BAKER, Rochester, *IV, '05,	John M. Lee, Chas. R. Clapp.
SIDNEY A. BECKWITH, Yonkers, I, '01,	R. Olin Phillips, Hills Cole.
FRANCIS E. BRENNAN, Flushing, I, '94,	Hills Cole, H. W. Paige.
WILLIAM M. CAMPBELL, Cohoes, V, '89,	H. C. Waldo, Reuell F. Benson.
STUART CLOSE, Brooklyn, I, '85,	R. C. Grant, C. C. Howard.
OLIN J. FRYER, Schenectady, I, '05,	F. M. Dearborn, L. B. Howland.
CRAWFORD R. GREEN, Troy, I, '06,	F. M. Dearborn, T. D. Buchanan.
WILLIAM H. HOPKINS, Geneva, I, '93,	Hills Cole, H. W. Paige.
ELMER G. KERN, Herkimer, II, '81,	C. E. Chase, D. G. Wilcox.
GARRY MOUNT, South Butler, III, '99,	J. L. Thorpe, John M. Lee.
CHAS. W. MÜLLER, New York City, I, '87,	Hills Cole, H. W. Paige.
FRANK I. NICHOLS, White Plains, I, '02,	Hills Cole, H. W. Paige.
WM. A. PRICE, Brooklyn, VII, '03,	H. D. Schenck, J. L. Moffat.
G. F. RAYNOR, New York City, I, '00,	Hills Cole, H. W. Paige.
ALLEN W. SAMPSON, Penn Yann, II, '80,	Hills Cole, H. W. Paige.
C. D. WELCH, Castleton, I, '77,	H. D. Cochrane, Hills Cole.
JOHN R. YOUNG, Liverpool, VI, '72,	Hills Cole, H. W. Paige.

*I. New York Homœopathic Medical College and Hospital.
II. Hahnemann Medical College, Philadelphia.
III. Cleveland Homœopathic Medical College.
IV. University of Michigan.
V. Albany Medical College.
VI. Hahnemann College, Chicago.
VII. Pulte Medical College, Chicago.

REPORT OF THE NECROLOGIST.

JOHN L. MOFFAT.

The year just past shows an exceptional depletion of our ranks by death. Nine of our members have left us tender memories and incentives to lead the simple, noble life which—occasions like this remind us—is alone worth while.

> "Footprints which perhaps another
> Wand'ring o'er life's stormy main—
> Some forlorn and shipwrecked brother—
> Seeing, may take heart again."

Of the nine, Doctors Hasbrouck and Sheldon were ex-presidents, and Doctor Laird had served as vice-president. Since the semi-annual meeting last October there has been one death—that of Francis E. Doughty, of New York, whose biography is herewith submitted with a resolution, the adoption of which is respectfully recommended.

March 7, 1906, Charles W. Townsend died in New York. March 16, 1906, Everitt Hasbrouck died in Brooklyn. June 11, 1906, G. I. Gifford died in Hamilton. July 23, 1906, Amelia F. von der Luhe died in Brooklyn. August 11, 1906, William de la Montayne died in Rondout. August 20, 1906, Frank F. Laird died in Atlantic City.

September 6, 1906, Jay W. Sheldon died in Syracuse. December 22, 1906, Frank H. De Camp died in Elmira. December 28, 1906, Francis E. Doughty died in New York.

NOTE.—For detailed report see the appendix of this Volume.

REPORT OF THE STATE BOARD OF MEDICAL EXAMINERS.

To the Homeopathic Medical Society of the State of New York:

The State Board of Medical Examiners representing your Society would respectfully report as follows:

In the past year one meeting of the board was held, at the office of the first Assistant Commissioner of Education, in the Capitol, February 13, 1906. At this meeting the president and secretary were re-elected. Drs. Gifford and Garrison were elected to represent the Homeopathic Board on the questions committee. The questions committee, as heretofore, is a joint body composed of six members, two from each of the three examining boards. The work of your board has progressed smoothly. Its members have been responsive to calls for time and effort in behalf of the interests of Homeopathy.

Results of medical licensing examinations in the academic year 1905-6 were as follows:

HOMŒOPATHIC BOARD.

Total number of candidates,			85
Full examination,		27	
Passed,	21		
Rejected (22.2%),	6		
Partial examination,			
Primary,		29	
Passed,	28		
Rejected (3.5%),	1		
Finals,		29	
Passed,	29		
Rejected,	0		
Honors,			5
Total number candidates in 1904-5,			66
" " " " 1903-4,			73
" " " " 1902-3,			77

OLD SCHOOL BOARD.

Total number candidates,			917
Full examination,		379	
Passed,	292		
Rejected, (23%)	87		
Partial examination,			
Primary,		262	
Passed,	258		
Rejected, (1.5%)	4		
Finals,		276	
Passed,	264		
Rejected, (4.5%)	12		
Honors,			14
Total number candidates in 1904-5,			1093
" " " " 1903-4,			992
" " " " 1902-3,			1011

ECLECTIC BOARD.

Total number candidates,			33
Full examination,		14	
Passed,	8		
Rejected (43%),	6		
Partial examination,			
Primary,		9	
Passed,	9		
Rejected,	0		
Finals,		10	
Passed,	10		
Rejected,	0		
Honors,			1
Total number candidates in 1904-5,			36
" " " " 1903-4,			33
" " " " 1902-3,			56

Number of diplomas indorsed upon recommendations of the boards:

Homeopathic,	3
Old School,	9
Eclectic,	0

In the fifteen years in which the medical licensing law has been operative, the following are total statistics for the several examining boards:

	EXAMINED.	PASSED.	REJECTED.	% REJECTED.
Homeopathic,	709	614	95	13.3
Old School,	9124	7337	1787	19.5
Eclectic,	295	206	89	30.1
Total,	10128	8157	1971	19.4

It is gratifying to note, this year, an increase in the number of Homeopathic candidates.

Respectfully submitted,

J. WILLIS CANDEE,
Secretary.

REPORT OF THE COMMITTEE ON INCREASING MEMBERSHIP.

Mr. President and Members of the Society:

Your committee begs leave to report that since the last meeting of the Society it has corresponded with every homeopathic physician in this State, whose name is listed in the last volume of the Society's Transactions, as not being a member of the Society. As a result of the sending out of seven or eight hundred letters to such physicians, we have received seventeen applications for membership, which we herewith tender to the Board of Censors for their approval.

Your committee presents a bill for printing, postage and mailing, of $14.81 and transmits to the treasurer $85 received with the application blanks.

HILLS COLE,
Chairman.

REPORT OF THE LEGISLATIVE COMMITTEE.

Mr. President and Members of the Society:

Your committee would respectfully report that on January 1, 1907, a sub-committee composed of Dr. J. W. LeSeur, Dr. Geo. E. Gorham and your chairman, held a conference with a sub-committee from the old school legislative committee composed of Chairman Arthur G. Root, Regent Dr. Albert Vander Veer, and Dr. Frederick C. Curtis, at Dr. Vander Veer's office.

After a discussion of two hours or more it seemed impossible to agree upon any common ground upon which the three recognized schools of medicine could work harmoniously in the legislature during the present session.

Finally, when all sources of argument had been exhausted, Dr. Root informed us that the Allopathic school would harmonize on no proposition except that of the single-board bill, which gives the Board of Regents absolute power, and it carries no Homeopathic or Eclectic representation. Your chairman immediately informed Dr. Root and his associates that if that was their final decision, the Homeopathic profession would fight them as long as there was breath of life in their bodies, and they would win in the end.

After a few moments of reflection they wanted to know if we had a plan to offer, and we said we had; *i. e.*, to pass an amendment to the present three-board law, defining the practice of medicine. They then asked if we could prepare such a bill within a week's time, and we replied that we could. They then said, "Prepare your bill and let us see if it is of such character as to enable us to join you and the Eclectics in its passage." We gladly consented, and within ten days again visited Regent Dr. Vander Veer and his two associates, Drs. Root and Curtis, together with Dr. King, Dean of the New York Homeopathic Medical College, Dr. Birch, of White Plains, and Dr. Spooner, President of the Eclectic Medical College, and its dean, Dr. Boskowitz.

Dr. Root, very early in the conference, held up our bill (which was really the definition of the practice of medicine as embodied in their single board bill) contemptuously and said it was no bill at all: nothing but a piece of paper, and that the only basis on which the Allopathic school would negotiate was the single board bill, with all of the objectionable features hereinbefore mentioned. We immediately withdrew from the conference with a firm determination to make good our announcement to the old school sub-committee that we would whip them.

Since that time your committee has mailed from its office an average of over two hundred letters and circulars daily; and public-spirited physicians all over the State have caught the enthusiasm and given us unusually vigorous and efficient aid.

All of the Homeopathic medical societies within the State of New York have passed unanimously, either since or before this confer-

ence, resolutions opposing the single board bill, and the same is true of the Eclectic societies.

Dr. Wilson, as chairman of the legislative committee of the Homeopathic Medical Society of the County of New York, and Dr. Moffat, as chairman of the committee on medical legislation of the Homeopathic Medical Society of the County of Kings, have worked harmoniously and strenuously with the committee of the State Society to defeat the abominable bill.

It has been ascertained by interviews with the Regents themselves that they, too, oppose any radical change in the present law, until the three schools of medicine are substantially a unit upon these disturbing questions. Regent Dr. Vander Veer and the officers in the Education Department, chiefly Dr. Draper and Dr. Rogers, together with the Allopathic profession, offer the only opposition to the law as it stands. The people and the other branches of the profession want it to remain in its present form.

The Homeopathic and Eclectic schools are working as one body to defeat the objectionable measure, and there is every prospect that we shall be successful.

The Osteopathic bill has received, and will continue to receive, our careful consideration, too.

I hand to you, Mr. Secretary, with this report the circulars which contain the arguments educed by the committee, which, it seems to us, ought to be appended and published as a part of this report, that the arguments may be preserved for future use.

Respectfully submitted,

JOHN M. LEE, M. D.,
Chairman.

REPORT OF THE BANQUET COMMITTEE.

The Chairman, DR. GEORGE E. GORHAM, reported as follows:

Mr. President, the banquet committee would respectfully report that they have arranged for a banquet this evening at seven o'clock. In place of the usual after-dinner speeches, two papers are to be read by visitors; one by Dr. John P. Sutherland, of Boston, on "Why Do We Eat? What Should We Eat?" and one by Dr. William C. Goodno, of Philadelphia, on "The Treatment of Acute Infectious Disease." We think there will be ample time for these papers, and possibly also for the President's Address, instead of listening to the latter to-morrow morning. We will have these papers immediately after the banquet, and that is why we call the dinner at seven o'clock. Tickets may be procured of Dr. Cochrane, who will be here most of the time, or at the desk of the clerk, at $2.00. We hope the members will not take their dinner at six, and then come to this banquet.

REPORT OF THE COMMITTEE ON EXHIBITS.

To the Homeopathic Medical Society of the State of New York, Greeting:

The Committee on Exhibits begs leave to report as follows:

Statement of Account.

Receipts:

From accounts receivable at last report, semi-annual meeting	$ 30.00	
From rentals at annual meeting in February, 1907, ten exhibits	175.00	$205.00

Expenditures:

Jan. 23, '07—	Stamps	$ 3.00	
	Meyer Bros., printing	5.25	
	Clerical, addressing	.50	
Feb. 7, '07—	Six telephone messages	.30	
	Stamps	.12	
Feb. 12, '07—	Typewriting attendance, sheets, bills, etc.	3.50	
	Ten banquet tickets	20.00	
	Rental of exhibit room	50.00	
Feb. 13, '07—	Railroad fares	6.20	
	Hotel bill, one day	3.50	
Feb. 22, '07—	Stamps and exchange	.40	$ 92.77
	Balance,		$112.23

The Committee has this day remitted to the treasurer the sum of $112.23, being the amount of the balance of cash on hand.

All accounts due the society as rentals for spaces in the exhibit rooms, during the incumbency of this committee, have been collected, except one account of $17.50 incurred by a vibrator concern, which is, without doubt, uncollectible, and should be charged to loss.

The Committee on Exhibits wishes to call attention to the vital importance of having early and accurate information as to the place, time and headquarters of each meeting. It is not possible to get the full value of our exhibit privileges unless the committee be given at least *two months' notice.*

Respectfully submitted,

BERT B. CLARK,
Chairman.

COMMITTEE TO NOMINATE STATE MEDICAL EXAMINERS.

The President appointed a special committee of three, consisting of Drs. George A. Shepard, Reeve B. Howland and A. W. Palmer,

to nominate a committee to nominate State Medical Examiners. They reported the following, who were, upon motion, elected by the Society: Drs. Chas. T. Haines, George T. Moseley, A. B. Van Loon, George W. McDowell and A. J. Warner.

ELECTION OF STATE MEDICAL EXAMINERS.*

Doctors H. D. Cochrane and Fred D. Lewis, appointed tellers to count the ballots cast for the selection of at least four nominees for State Medical Examiner, from whom the Board of Regents are to select two, reported as follows:

Ballots cast, 22. John B. Garrison, 13; Lynn A. Martin, 13; Gordon W. Hoyt, 11; Joseph T. Cook, 9; Frank P. Warner, 7; G. De Wayne Hallett, 14; D. M. Hibbard, 13; Charles E. Birch, 12.

The President thereupon declared Drs. Hallett, Garrison, Martin and Hibbard as the nominees of the Society.

REPORT OF COMMITTEE ON PRESIDENT'S ADDRESS.

Fellow Members:

Your Committee begs leave to submit the following report upon the masterly address of President Newton M. Collins:

First. With the sentiments regarding liberality, so well expressed, and closing with the words, "What we need is liberality, more personal contact with members of other schools, and cast aside all those prejudices that have been handed down from the time when prejudices meant our very existence," your Committee is in accord, and recommends that the members cultivate this spirit so far as possible, at the same time maintaining their self-respect as homeopathic physicians.

Second. We recommend that Section 2 of Article IV. of the By-Laws be amended by adding at the end the words, "Physical Therapeutics."

Third. That the Secretary be directed to send to each county and sectional society in this State a letter calling the attention of the organization to the evils of contract-physician work, and asking each organization to call the attention of its membership to this prostitution of the high standing of the profession of medicine to petty financial gain, and to take all reasonable steps to check this abuse.

Fourth. We recommend that the garnishee law be amended so as to include physicians in its provisions.

HERBERT D. SCHENCK,
GEORGE E. GORHAM,
JOHN W. LE SEUR,
Committee.

***Secretary's Note:—The subsequent enactment of a State law consolidating the former three Medical Boards into one State Board of Medical Examiners consisting of nine members and appointed by the State Board of Regents, rendered the above action inoperative and also nullified Article VI of the By-Laws of this Society.**

MEMORIAL RESOLUTIONS.

Upon the Death of Governor Frank W. Higgins:

Drs. Moffat, Brown, Le Seur and Hibbard, as a special committee, presented the following resolution, which was adopted:

Whereas, Under Divine Providence, Ex-governor Frank W. Higgins has at last obtained relief from the pains, sorrows and labors of this earthly life;

Whereas, Governor Higgins was a good friend of this Society, and a believer in Homeopathy;

Resolved, That the Homeopathic Medical Society of the State of New York expresses its sense of loss, and extends to the family its sincere sympathy.

Upon the Death of Dr. Francis E. Doughty:

The Necrologist, Dr. John L. Moffat, embraced in his report the following, which was adopted:

Whereas, In the order of His Divine Providence it has been the will of God to take from us by sudden illness our esteemed member, Francis E. Doughty, in the fullness of his influence, faculties and character; and

Whereas, Dr. Doughty long held the respect of the community, the confidence and affection of his patients, the love of his students and the esteem of the profession through his personal charm, scrupulous integrity, kindly helpfulness, modesty, gentleness and high sense of justice; and

Whereas, His career as a physician and surgeon was characterized by thoroughness of preparation, accurate knowledge, conservative judgment, operative skill and probity in consultation;

Resolved, This Society places on record its regret at the loss of one who for over a third of a century has contributed more than the average to the advance of Homeopathy by his personal influence, as well as through his college lectures and clinics, and by his contributions to our societies and literature.

ELECTION OF OFFICERS.

The Tellers appointed to canvass the vote for the election of officers reported as follows:

Total number of ballots received		81
Rejected for being defective	14	
" because blank	11	25
Leaving ballots counted		56

For President:

Herbert Dana Schenck, Brooklyn 56

For First Vice-President:

F. W. Adriance, Elmira 54

For Second Vice-President:
William A. Keegan, Rochester 53
For Third Vice-President:
H. D. Cochrane, Albany 53
For Secretary:
H. Worthington Paige, Oneonta 54
For Treasurer:
Reeve B. Howland, Elmira 54
For Necrologist:
John L. Moffat, Brooklyn 54
For Counsel:
F. E. Wadhams, Esq., Albany 53
For Censors—Southern District:
D. J. Roberts, New Rochelle, for three years 46
Chas. E. Teets, New York, Mhn., for two years 47
Nathaniel W. Ives, Mt. Vernon, for one year 45
For Censors—Eastern District:
Frederick I. Cox, Albany, for three years 43
H. L. Towne, Schenectady, for two years 43
H. P. Deady, Liberty, for one year 45
For Censors—Middle District:
Chas. T. Haines, Utica, for three years 46
Chas. A. Ward, Binghamton, for two years 42
Louis D. Hyde, Owego, for one year 44
For Censors—Western District:
George T. Moseley, Buffalo, for three years 45
Thomas Parsons, Rochester, for two years 48
F. P. Warner, Canandaigua, for one year 45

Signed: CHARLES T. HAINES,
A. R. GRANT,
H. WORTHINGTON PAIGE,
Tellers.

The report was adopted and the President declared the officers above named elected.

MISCELLANEOUS BUSINESS.

ELECTED HONORARY MEMBERS:—Dr. Howard P. Bellows, Boston, Mass., and Dr. Royal S. Copeland, Ann Arbor, Mich., were unanimously elected to honorary membership in the Society.

SENIOR MEMBER:—Dr. Henry G. Preston, 68 Greene Avenue, Brooklyn, was elected a senior member, having been an active member since 1875.

DROPPED FOR NON-PAYMENT OF DUES:—Upon recommendation of the Treasurer, the following names were dropped for non-payment of dues: Drs. Harry Zeckhausen, B. L. Van Buren, Otis H. Babbitt, Thos. F. Davies, W. C. Latimer, O. W. Smith, A. Lenora White.

RESIGNATIONS:—These members tendered letters of resignation, which were upon motion accepted: Mary A. Brinkman, J. C. White, F. W. Cornwell and Lizzie Safford Gillespie.

REGARDING MEDICAL LEGISLATION:—Drs. Moffat, Gifford and Le Seur presented the following, which was adopted: *Resolved:* This Society considers the present three-board system of medical examiners entirely satisfactory, and recommends that no change be made.

NOTICE OF EXPULSION:—The Secretary read a letter from Dr. R. C. Scott, of Fulton, N. Y., Secretary of the Oswego County Homeopathic Medical Society, containing an official notice to the State Society, of the expulsion from the Oswego County Society of Dr. E. L. Hinman, of Oswego, N. Y., on December 11, 1906.

PROPOSED AMENDMENT TO BY-LAWS:—Notice was given of an amendment to By-Laws, Article IV., to be acted upon at the next annual meeting, creating a "Bureau of Electio-Therapeutics."

CONTRACT SERVICES:—A motion was adopted expressing the positive disapproval of the Society of prevalent forms of "contract medical service," as in the case of factories, stores, social, insurance and fraternal organizations; such agreements being regarded as unethical and unprofessional.

TO CONTROL HABITUES:—The following resolution, introduced by Dr. J. T. Greenleaf at the conclusion of his paper, was adopted: *Resolved:* That the Homeopathic Medical Society of the State of New York instruct its Committee on Legislation to prepare and secure the passage of a law which shall provide for the legal control of the person of all those who are addicted to the use of narcotics or stimulants to an extent which renders them useless to society, or leads them to waste their property.

"THE UNFORTUNATE BORDERLANDER:"—The subject-matter of Dr. Seward's paper under this title was, upon motion, referred to the Committee on Legislation, with instructions to consider the subject and report thereon at the next semi-annual meeting. The essence thereof being the wisdom of some legal enactment looking to the taking of cases of simple, acute and curable nervous disorders presenting mental symptoms, from their present legal classification with the insane.

NEW STANDING RESOLUTIONS ADOPTED.

A.—Every account of an officer or committee exceeding twenty dollars in amount shall be passed upon by an auditing committee before payment.

B.—The Society shall not invite more than one Guest to contribute to the proceedings of any given meeting.

C.—The Treasurer is authorized to employ a collector at his discretion.

D.—No paper shall be announced on the program of more than one meeting except by a vote of the Society.

THE ANNUAL BANQUET was held in the ball room of the Hotel

Ten Eyck on Tuesday evening. In lieu of the usual post-prandial speeches, the President, Dr. Newton M. Collins, delivered his annual address, followed by two papers, "Why Do We Eat? What Should We Eat?" by Professor John P. Sutherland, Boston, Mass., and "The Treatment of Acute Infectious Disease," by Professor William C. Goodno, Philadelphia, Pa. The address and both papers are published elsewhere in this volume.

SCIENTIFIC PROGRAM.

FIRST DAY—MORNING SESSION—11:15 O'CLOCK.

PUBLIC HEALTH.

F. W. ADRIANCE, *Chairman.*

The Tuberculosis Problem in the Hospital for the Insane
R. E. Mitchell

CLINICAL MEDICINE AND PATHOLOGY.

HAROLD D. COCHRANE, *Chairman.*

Why Do We Eat? What Should We Eat?
Prof. John P. Sutherland, Boston, Mass.

The Treatment of Acute Infectious Disease
Prof. William C. Goodno, Philadelphia, Pa.

Nervous Dyspepsia - - - - - - George F. Laidlaw

PÆDIATRICS.

GORDON W. HOYT, *Chairman.*

Dietetic Methods in the Nutritional and Gastro-Intestinal Diseases of Infancy and Early Childhood
J. T. Simonson

Infantile Malnutrition - - - - - - - C. E. Chase

FIRST DAY—AFTERNOON SESSION—2:00 O'CLOCK

MATERIA MEDICA.

CLARENCE C. HOWARD, *Chairman.*

Precision in Homeopathic Prescribing - - Stuart Close

A Few Cases Illustrating the Superiority of Homeopathic Therapeutics - - - Daniel E. S. Coleman

Observations on the Homeopathic Therapeutics of Tuberculosis - - - - - - Guy B. Stearns

A Consideration of the Relationship Which Our Materia Medica bears to the Treatment of Disease Rudolph F. Rabe

NEUROLOGY.

D. H. ARTHUR, *Chairman.*

Constitutional Inferiority; with a report of two cases — Frederick C. Robbins
The Unfortunate Borderlander - - Frederick W. Seward, Jr.
The Control of Cases of Addiction - - John T. Greenleaf

SURGERY.

BUKK G. CARLETON, *Chairman.*

Operations in Two Stages - - - - William H. Bishop
The Diaphragm as a Barrier to Infection - J. Herbert Irish
Diagnosis of Appendicitis by Exclusion - Orando S. Ritch
Thyroidectomy - - - - - Dewitt G. Wilcox
Shock and its Treatment - - - - W. Louis Hartman

GYNÆCOLOGY.

GEORGE T. MOSELEY, *Chairman.*

The Backache of Endocervicitis and Its Cure by Operation - - - - - - - - Homer I. Ostrom
The Results of Ventro Suspension - Arthur Rogers Grant
The Results of Some Uterine Infections, Wm. Francis Honan

SECOND DAY—MORNING SESSION—10:15 O'CLOCK.

OPHTHALMOLOGY AND OTOLOGY.

ELMER J. BISSELL, *Chairman.*

Splenic Leukæmia; The Eye as a Possible Source of Infection - - - - - - - W. H. Doane

LARYNGOLOGY AND RHINOLOGY.

H. W. HOYT, *Chairman.*

Submucous Resection of the Septum - A. Worrall Palmer
Breathing - - - - - - - Fred D. Lewis

REPORT

OF THE

BUREAU OF PUBLIC HEALTH.

"The Tuberculosis Problem in the Hospital for the Insane," - - - - - - - - - - ROY E. MITCHELL.

THE TUBERCULOSIS PROBLEM IN THE HOSPITAL FOR THE INSANE.

ROY E. MITCHELL,
STATE HOSPITAL, MIDDLETOWN, N. Y.

A part of the limelight that for some years has been turned on the general problem of tuberculosis has fallen on a less widely exploited, but nevertheless quite important question—the consideration of the tubercular insane.

We gather some conception of the numbers involved from the United States census report of 1903, which states that there are 150,000 insane persons in the various institutions for the insane of the country. This number is gradually increasing. During the past seventeen years fifteen per cent. of those dying in the New York State hospitals have died of some form of tuberculosis. This is a reasonably careful estimate, but from the nature of things it is probably conservative. When we compare it with the general tubercular death rate of twelve per cent. (United States Census, 1900), it assumes still more significance.

In this paper I propose to review the work done in this line at Middletown during the past four years. It may be suggested that the subject-matter applies more particularly to local conditions, but I think that this is not the case. The great majority of the insane fall into fairly well-defined groups, and these are to be found in all institutions. The relation of these groups to each other may vary to some extent in different hospitals, but in general I think they will average up pretty well.

It has been said that the patients received at Middletown average better (from the social and intellectual point of view) than those of any other New York State hospital, and I believe this to be true. In so far as this is a factor, we have that advantage over the other

hospitals in the treatment of tuberculosis. But from their nature, the greater part of the difficulties which I am about to take up are to be met everywhere.

So far as I have been able to determine, the social status of our patients prior to commitment is much the same as that of the sane tubercular patient. The same etiological factors have been at work, the same paths of infection have been traversed, and the same pathological changes are in evidence. In short, in the beginning the insane tubercular patient is in no way different from the sane tubercular patient from the strictly physical point of view.

But at this point entirely new conditions arise that have a material bearing. First of all, the patient's mental condition has to be considered. This is a variable quantity, but in the majority of our cases there is some degree of deterioration present. In any event, there is always a serious mental condition present which frequently overshadows the tubercular process. The actual and potential loss of the insane patient to the community, because of his tuberculosis, does not figure so largely as does the sane patient, because he is already removed from civil life on account of his mental trouble. This alone, in the majority of cases, will render him subject to custodial care for the rest of his life. When we consider that a good percentage of these patients are public charges, this economic side is of still less significance.

In the treatment of the individual case, difficulties not ordinarily experienced crop out. We all know how hard it is to make a definite diagnosis at times, even with the most favorable co-operation of all concerned. In some of our cases it seems as if everything tended to obscure the case. The clinical history was often negative. Frequently the friends knew of nothing positive, occasionally they were evasive; and, of course, the patient's own story had to be taken with more or less reservation. Because of the mental condition, the subjective symptoms are no more reliable. A paranoid patient may conceal them, or, thinking them a part of his persecutions, take them as a matter of course, and mention them only casually. A manic case feels well, is elated, and so busy with various things that he is apt to make light of them. The depressed patient may feel that it is not worth while to discuss his case; no matter if he is sick, a serious illness may end his troubles. The deterioration types are likely to be too demented to give intelligent co-operation, or are too indifferent to care about themselves. In some of the more intelligent cases I have found that there is a tendency toward evasion and to make light of anything that points toward tuberculosis (a trait that, in my experience, is not limited to the insane patient). A few of our patients co-operated quite as well as one could wish. Our main reliance, then, is of necessity the physical complex; but here again the problem is not always easy.

In some the diagnosis is merely a matter of being familiar with

the physical signs. In some the co-operation in examination is indifferent. In others, especially deterioration types, the patient is passive, pays little or no attention to requests, and says nothing. Some suspicious cases resist the physical examination, and right actively at times, so that the findings are more or less unreliable.

In almost all of the cases the last doubt was removed by the finding of tubercle bacilli in the sputum. Considerable difficulty has been experienced in getting satisfactory specimens from all. Some patients persist in swallowing their sputum, others expectorate about promiscuously; occasionally there is a patient who tries to avoid giving a specimen of sputum just as hard as you work to get it, and gains his point. A number of times we have been obliged to go on the ward and make the smears from a bit of sputum which has fallen on fresh sheets spread for that purpose. The monthly weight list has been the most reliable source of early information, a gradual loss of weight being the only thing to call special attention to some patients. The cough comes so late, and is so easily overlooked in a good many cases, that we have not given it the early diagnostic importance that it usually receives. We have been disappointed in getting the usual temperature curves, but this is possibly due to other causes; at least more data must be had before any definite statement is made. Diverse combinations of these various things have come along in the course of our clinical work, and have caused much more work than one at first would think warranted. So puzzling is the diagnosis at times, that we think of tuberculosis for months without being able to say so definitely; then something happens and the disease comes out clearly, perhaps to pursue a typical course. We have made some mistakes in diagnosis, some errors in both directions, but I do not recall a case in which any particular harm came to the patient because of them.

So far as the mental condition permits, we aim to treat our patients in accordance with the generally accepted methods; bed treatment at first, plenty of light and an abundance of fresh air, are the first things looked after. Unless something contra-indicates, a generous mixed diet and plenty of milk are given each patient. The remedial treatment varies; it is considered of secondary importance. Isolation is carried out so far as the present building arrangements permit, except with a relatively small number of intelligent patients. We have had to exercise unusually strict hygienic measures because of the carelessness and lack of co-operation on the part of some patients. As much of the sputum as possible is collected in vessels containing germicides, that of untidy patients on sheets spread about the beds. No sputum is allowed to dry. The floors are scrubbed daily with disinfectants. No dust is allowed to accumulate. The dishes and other utensils are scalded after use. The bedding and all soiled linen is carefully collected and sterilized by steam prior to the regular laundry regime. Twice a year the ward is given an especial overhauling and is then fumigated with formaldehyde.

In general, we may say that the prognosis is not so favorable as among sane persons. The large percentage of more or less deteriorated patients accounts in part for this. With these, the active interest and hearty co-operation that the patient should have are replaced in varying degree by desultory co-operation, passivity, obstinacy and resistance. On the other hand, the deteriorated patient is not so apt to worry about himself, a condition so frequent in general practice. Nor does the manic case worry; he makes too light of physical ills, and at times it is a problem to control his activity so that he will not exhaust himself to such an extent that the tubercular process gets a firmer hold. I regard these as the most favorable cases, for as soon as the period of hyperactivity passes, they co-operate well. The knowledge that he has tuberculosis is apt to make the depressed patient more depressed; another trouble has come to one already overburdened; there is something more to worry about. The paranoic case may regard the statement that he has tuberculosis with distrust, and tell you that you misinterpret the changes that have occurred in his lungs, making an explanation in accordance with his delusional developments. Some of these patients will listen to a reasonable explanation, others reject it peremptorily. Too much attention to a patient may cause him to think that you have an undue interest in him. The co-operation that such patients give is obviously variable and capricious.

In the senile cases the tubercular condition is usually a very old process and fairly well localized; something that drags on for years until failing health favors an extension of the disease, or some intercurrent trouble takes them off.

In the exhaustion type of psychosis, tuberculosis may be one of the leading factors, and as such must be considered of grave importance.

Clinical Review.—During the past four years 155 cases of tuberculosis have been treated, 77 men and 78 women. Of these 23 were considered incipient, 106 in a more advanced stage, 25 latent or old fibrous retracted apices, and 1 case of general tuberculosis. 2,208 patients have been cared for during this time; practically six per cent. of them were tubercular.

The mental diagnosis of these cases (Kraepelin's terminology) was as follows: Dementia præcox 78, epileptic psychoses 10, senile psychoses 19, general paresis 1, intoxication psychoses 10, infection and exhaustion conditions 5, manic-depressive insanity 12, melancholia of involution 11, paranoic condition 6, psychæsthenia 3. Observe that 70 per cent. of these cases were of the various deterioration psychoses, and that one-half were dementia præcox types. This is partially accounted for by the fact that the population of almost all large insane hospitals is made up chiefly of deteriorated persons.

The results of treatment, summed up briefly, follow: 33 cases (21 per cent.) arrested; 6 cases latent or fibrous apices; 18 cases

discharged improved; 2 cases discharged not improved; 48 cases (31 per cent.) remain active; 48 cases have died. Of those cases active at the present time, 80 per cent. are of the various deterioration types. They approximate 3½ per cent. of our present population (1300).

Autopsy Review.—In one-half of the patients autopsied during this time (160 cases) tubercular lesions were found. In those cases dying of tuberculosis (21 in number) 3 were found with healed lesions in one lung. In those dying of other pulmonary conditions (11 cases) 5 showed healed lesions in both lungs, 5 in one lung, and 1 showed both healed and active lesions.

Of those dying of various other diseases (128 cases), 24 showed healed lesions in both lungs, 14 had healed lesions in one lung, 6 had both active and healed lesions, 6 had active lesions in one lung and 2 had solitary intestinal lesions (ulcers and enlarged mesenteric glands).

The significant fact of this review is this: 48 (30 per cent.) cases had healed lesions that in all probability had not the remotest relation to the cause of death, while 15 cases (9 per cent.) had active lesions of such minor importance that they were not considered of special significance.

General Outlook.—It is difficult to say at so early a time just what will be accomplished in this field. A good beginning has been made and the interest seems fairly widespread. New York has made special provision for tubercular patients at four State hospitals, and no doubt more will be done as the need is shown. A number of other states have made, or are about to make, similar provision.

The results of the treatment of this class of patients can hardly be expected to compare favorably with that done on the outside. The matter of isolation is practically under absolute control, and this alone should insure a steadily decreasing death rate. Some of the difficulties I have enumerated will partially offset this one excellent feature.

In following out this special work the general tuberculosis problem should always be kept in view. Intelligent consideration of the details, systematic routine and persistent work are the essentials. Supply these, and a reasonable degree of success is bound to come in time.

REPORT

OF THE

BUREAU OF CLINICAL MEDICINE AND PATHOLOGY.

"Why do we eat? What should we eat? - - - - JOHN P. SUTHERLAND.
"The Treatment of Acute Infectious Diseases," - - WILLIAM C. GOODNO.
"Nervous Dyspepsia," - - - - - - - GEORGE F. LAIDLAW.

WHY DO WE EAT? WHAT SHOULD WE EAT?

JOHN P. SUTHERLAND, M. D.,
BOSTON, MASS.

A very great many years ago, when I was a boy and played at conundrums, we used to ask each other—"Why is a bad clergymen like a sign-post?" To which the answer was—"Because he points the way he never treads." As I rise to-night to speak to you on my chosen subject, "Why Do We Eat? and What Should We Eat?" I feel very much like the bad clergyman and the sign-post of our boyish conundrums; I, on this occasion at least, am so conspicuously pointing the way I am not treading. For I shall presently tell you, with *ex cathedra* solemnity, that we should eat for necessary nourishment, and not for gratification of the palate by agreeable flavors; whereas the agreeable flavors of the food you have so bountifully set before me have tempted me far past any need of amplest nourishment. I shall preach to you of the severely hygienic composition of the dishes of which alone the conscientious scientist will partake, while I very much fear that several of the dishes I have so visibly and unblushingly enjoyed do not stand catalogued in any hygienic cook book. I can only plead the precedent of our remote common ancestor for unprincipled partaking of agreeable, *but forbidden fruit*, and remind you—to borrow yet another quotation from boyhood days—that

In Adam's fall,
We sinned all!

I am offering you to-night two dietetic conundrums. Why do we eat? What should we eat? I am not promising you anything very final and comprehensive in the way of answer. I hope to offer a hint or two as to the fields in which answers are to be sought.

Since reading J. Milner Fothergill's little book, "A Manual of Dietetics," some twenty years ago, my attention has more and more definitely been turned in the direction of the etiological potency of diet, and I have pursued the subject of diet from the etiological standpoint more or less fitfully ever since. Hahnemann, the founder of Homeopathy, spent, as you know, many years in the study of chronic disease, and formulated a theory, which has measurably stood the test of time, that the great majority of chronic diseases are due to one of three miasms. Whether or not he was fully justified in his conclusions, I do not propose to discuss; but I confess it does not seem to me that Hahnemann, or any of the other students of chronic diseases, has attributed to diet anything like its very probable etiological possibilities. We hear a great deal of conditions that are said to be due to climate and to atmospheric influences. The profession and the laity have long considered climatic influence a sufficient explanation of the cause of many diseases. Personally, I am inclined to think that climate is of very much less universal significance, as the etiological factor of disease, than is improper diet. I believe climatic influence has been too much dwelt upon, etiologically, and dietetic influences have been far too generally ignored.

Bacteriological science has quite definitely determined that the majority of acute diseases are due to the activities of micro-organisms, and that most of the acute diseases are self-limited in nature; that while many of them are contagious and infectious, and may rage as wide-spread epidemics, they will, with good nursing, with simple dietetic and hygienic treatment, barring complications and constitutional difficulties, terminate in good recovery. But it is quite different with the hosts of chronic and unclassifiable pathological conditions with which the physician has to deal. The tendency of a large number of these chronic troubles is not to dissolution. They are not self-limited, and spontaneous recovery from them is a rare occurrence. It is this class of cases that tries the patience, the skill, and the ability of the physician to the utmost, and it is just this class of cases that must be cured by artificial means, since Nature, unaided, seems unable to bring about a recovery. Such conditions are not due to micro-organisms. They will, in many cases, be found to be amenable neither to surgical treatment nor to medicine. The administration of drugs singly or in combination, in high or low potency, may be quite ineffective to bring about the desired cure. All the resources of medical art are usually needed. And not the least helpful of these resources will usually be a careful inquiry into, and a proper regulation of, diet. If we consider, solely and exclusively, the benefit we may confer on our chronic patients by answering to them and for them the questions—"Why do we eat?" "What should we eat?" we shall find the time spent in seeking answers to these questions to have been profitably spent.

Again, one of the noblest uses of the medical profession is the

prevention of disease. And it is certainly to the great credit of the profession that within recent years much has been accomplished in the way of bringing forward measures that will prevent the occurrence of many infectious diseases. The terrible scourge of smallpox was one of the first enemies of mankind to succumb to preventive measures. Pulmonary tuberculosis is likely to become of much less frequent occurrence on account of measures which are now being taken to prevent its spread. It is claimed that 14,000 deaths occur annually in the State of New York from this one disease, a mortality that is almost, if not quite, preventable. Malaria, yellow fever, and to an extent, diphtheria, are becoming more and more amenable to preventive measures. To make such measures effective it is necessary, first, that the profession shall be properly educated; secondly, that the laity shall, by educated physicians, be taught all that is knowable concerning such matters; and finally, that there shall be earnest and cordial co-operation between the profession and the laity, on the basis of such knowledge. It is through such an educative campaign that tuberculosis is being more and more controlled, that smallpox is becoming less and less prevalent, and that epidemics of yellow fever are becoming more and more manageable. The glories of preventive medicine, however, seem to be connected with such infectious and contagious diseases as the above-mentioned; and this is due, primarily, to the fact that the *causes* of these disorders have been clearly and definitely recognized. May we not assume that if the causes of any number or variety of chronic conditions could be as clearly and definitely recognized as the causes of these acute maladies have been, something as satisfactory in the way of preventive measures might result as has resulted in the case of acute diseases?

It seems a very curious fact that mankind should be subject to so many disorders. Of all the animals it is claimed, at least by himself, that man is the most intelligent. His knowledge is far reaching; his mental ability far transcends that of any of the animals. It is within his power to control his environment. It is possible for him to procure fresh air, to modify his clothing, to protect the body against intense cold or excessive heat. It is possible for him to so order his life as to make use of or avoid sunshine; to make use of bathing and other measures for cleanliness. Not least to be considered, his food is a matter of his own selection. He certainly is not limited in the variety of foods at his disposal, as are the other animals. It would seem as if, with the aid of so much knowledge, intelligence and power, he should suffer far less from disease conditions than the animals. Yet, as a matter of fact, he boasts far more diseases and more illnesses than all the other animals combined. I am inclined to think the explanation for this not very creditable condition of things lies in the fact that in spite of man's knowledge he does not know enough; and that where his knowledge *is* sufficient, he does not allow this knowledge to guide his actions. With

almost infinite freedom of choice, there seems woefully lacking the intelligence and the will to choose wisely; even in the one particular of knowing and willing when and what to wisely eat.

Why do we eat? The answers to this question are imaginably almost as numerous as the imaginable divisions of those to whom the question might be put. The normal small boy would reply that we eat because—and whenever—a kind Providence brings eatables our way. The careful housewife would reply that we eat because the servants object to having the table kept waiting. The gourmet would reply that we eat because eating, under wise precautions, offers one of the keenest pleasures life affords; and one that can be enjoyed practically to life's end. The physician of slightly belated theories would answer that three meals a day, eaten at regular hours, promote digestion and health. The broad-minded, up-to-date scientist would give us an answer differing very widely from any of these. He would, and in the persons of the best modern dietetic authorities does tell us, that we eat because protoplasm must consume and assimilate nourishment in order to form new protoplasm and to repair that waste of protoplasm which is implied in putting forth any form of energy.

I hope to show you that in accepting the latter statement we are answering not only one, but both questions which head my paper. It tells us why we eat; simply that by consumption and assimilation of food we may repair the waste of our system; keep its machinery well oiled and adequately supplied with motive power. And by implication it answers the second question. If our reason for eating is to manufacture protoplasm and to repair waste, then, surely, reason dictates that we shall eat only the food that can most promptly, economically, lastingly and wholesomely repair that waste, or be converted into protoplasm.

The answer to "Why do we eat?" also implies a very pregnant suggestion as to when we should eat, and how much we should eat. It suggests that we should eat oftenest when most the tissues need repair, and that we should proportion our food to the amount of repair needed.

An engine is fed according to the amount of work expected of it at any given time.

A horse is fed extra oats if extra work is expected of him; while he is fed on grass or put to pasture if he is not expected to do work for the time being.

There seems no reason why man should not treat his own mechanism as intelligently as those he creates of iron and steel; certainly, the latter are renewable if destroyed, and his own does not possess that pleasing attribute. There is no reason why he should not deal with his own animal needs as wisely as with those of the other animals committed to his ownership.

It is a hopeful sign that we are losing the tradition that three "square" meals a day are necessary to all men at all times. The

no-breakfast theory has helped much to emancipate us from the three-meal tradition; so, on the other side of things, has the forced-feeding theory. We are slowly learning that we are meant to eat for use; not for tradition nor for amusement.

In trying to answer the practical question, "What should we eat?" we find ourselves face to face with a very difficult problem. It would seem to be one of the easiest questions in the world to answer, but if we think of it carefully, it is in reality one of the most difficult. In what direction shall we look for the answer? From what source shall we expect to get light? Shall we accept as our standards the diet lists furnished by manufacturers of digestive ferments or of special foods? Kind Heaven forbid! Shall we accept the menus furnished by physical culture laboratories, diet kitchens, cooking schools, etc? We shall do so at the peril of our temporal, and possibly our eternal welfare. Shall we be guided by the directions furnished by some of the older writers? By Pavy, Liebig and others? Or shall we accept the more modern dictum of Chittenden or of the well-known Fletcher? Here we are "getting warm," as the children say; but we have not yet arrived. If we look at the dietaries of the various peoples of the earth for the answer to our question, we shall find ourselves helplessly confused. For the dietetic habits of various nations and peoples are as varied as their other customs. We need but quote the rice and fish of the Japanese; the rice of the Chinese; the ascetic vegetarianism of the Hindoo; the fruits of the South Sea Islanders; the culinary ancestor-worship of the Pategonians; the black bread of the Italians; the oatmeal of the Scotch; the potato of the Irish; the beef of the English; the baked beans and brown bread and codfish of the Bostonian; the hog and hominy of the South; the venison of the American Indian; the blubber of the Eskimo. Little suggestion as to the most hygienic diet for humanity would seem to be obtainable from comparative methods. We certainly cannot be guided by those who advocate uncooked food, by those who advocate exclusively a meat diet, or by bigoted partisans of vegetarianism. We cannot glean any broadly general suggestions from the dietetic habits of the wealthy and luxurious, or, on the other hand, from those whose circumstances permit only the meagerest fare. We certainly cannot find an answer to our question in what is called natural instincts, because our instincts are no more reliable in this respect than in any other, and are as likely to lead us in the wrong direction as the right. If we could properly interpret Nature, we might find something nearer an answer, for Nature very evidently prepared for man's existence and well-being, even before man himself was far developed.

It seems certain that the only permanent and worthy answer to our question can come from the physiological laboratory, where Nature is respectfully and intelligently questioned; in that properly conducted experiments are actually performed. The brilliant work done by Atwater, of Wesleyan, and Chittenden and Fisher, of Yale,

is destined to furnish most important information as to the true values of various foods. And as mankind advances in intelligence and in ethical culture, it is certain he will eat more intelligently, and we may say more ethically; another way of saying that he will eat with the primary intent of building up healthy and useful tissues—to building cleanly mansions in which for his higher self to dwell; and useful, trustworthy vehicles through which for his higher self to find expression. To do this he must obtain all possible knowledge about food values; and he must utilize this knowledge in his personal dietary, and in his teaching and direction of others. This does not mean that man is to make of eating merely an uninteresting, uncongenial performance of a duty. There is no imaginable reason why wholesome food should be unpalatable. And as for enjoyment from eating, one has only to compare the sated gormand waving away with a nausea of distaste the choicest dishes of the most famous chefs, with the schoolboy, new from the football field, joyously munching his bread and butter and apples; one has only to compare these two to realize that enjoyment in eating is not largely a matter of the flavor of things eaten. When we eat wisely, we shall not lack pleasure in eating. Pleasure in the exercise of necessary functions is "Nature's shilling" to bribe us to that exercise. And Nature never shirks her end of a bargain. Let us agree that Nature's answer to "What shall we eat?" is that we should eat what we most need to secure maintenance of healthy tissue. What that is, life and our laboratories are from day to day instructing us. To begin with, Nature has furnished man with a good many hints as to what he should eat by supplying him abundantly with certain food materials; that is, material which is convertible into healthy and active protoplasm. Grains are to be had in great variety. Vegetables, fruits and nuts are also freely provided. So far as Nature is concerned, however, the only comprehensively perfect food that she provides, for mammals, at least, is milk; the quality of the milk varying more or less with the species. The constituents of this form of nutriment are too well known to require dwelling on in detail. But it may be well to remind ourselves that this most valuable food consists of fat, sugar, proteid and chemical salts in solution or suspension in a very large proportion of water. Since milk can, by itself alone, sustain life for such prolonged periods, alike in infancy and in maturer years, in sickness and in health, it is safe to infer that if we supply to ourselves in whatever forms of food we choose, fat, sugar, proteids, chemical salts and water, we shall be well and properly nourished, provided that we neglect none of these in our dietary, and that we justly regulate the proportion of each.

I am not prepared to suggest to you a fixed dietary. My purpose is rather to urge on your attention the importance of intelligent dietetic study; the etiological and therapeutic importance of dietetics as a whole. But I shall trespass on your patience with a few hints and suggestions; some of which may strike you as rather

heretical, but all of which I have made proof of in many years of personal and professional experience.

First let me say that the popular idea that meat is the one and important essential article of man's diet does not in any way meet with my approval. It is very true that one of the distinguishing characteristics of all forms of animal life is the necessity of some proteid food. This is one of the differential points between animal and vegetable life. It is also true that meat is a proteid food and that it yields its nitrogenous elements very readily. It is oftentimes said to be more digestible than vegetables, and it is also said to be transformed vegetable matter. That it is easily digested there can be no doubt. But a great and insuperable objection in my mind to the free use of meat is the fact that it has lived, and as a result of its activities in that life it is more or less loaded with waste matter. Some of these physiological wastes are not in the least injurious. Many of them, however, are of known toxic potencies. And it is the ingestion and absorption of these toxic substances that in my mind make meat a distinctly objectionable article of food. We often hear a careful housewife speak of removing all the fat from a bowl of soup or broth; we often hear people say that they have used the expressed juice of so much meat a day, thinking that they have removed injurious matter, or secured a more wholesome food by such procedure. As a matter of fact, the fat which has been so carefully removed is an excellent heat producer, and may be needed by the invalid; and the soup which has been so carefully strained, and the juice which has been so carefully expressed, skillfully preserve all the dangerous waste matters found in the meat itself. Anyone who wishes to take the necessary time can easily demonstrate to himself that meat juice contains the waste elements and poisonous substances found in urine; not an appetizing truth to ponder! The delicate calves' liver so highly prized by epicures; the toothsome kidney stew considered so palatable, are both of them, from a physiological standpoint, what the brutal candor of a surgeon would truthfully call "dirty." For they contain even a larger proportion of physiological waste than plain or ordinary meat. The natural, and I believe the just conclusion from these facts is that the smaller part meat plays in man's diet, the sounder and cleaner tissue will he build up. Always provided that the place of the proteid now furnished by his consumption of meat be supplied by the free use of eggs, nuts, cheese and other articles of diet equally rich in this element, in clean and easily assimilable form. Proteid and meat are far from synonymous terms. That man is necessarily a carnivorous animal is rapidly becoming an exploded superstition.

If we look at the animal kingdom we shall find those animals that are exclusively meat eaters are not, from any standpoint, the most desirable or useful members of that kingdom. Carnivorous animals are notably savage, brutal, undocile and unserviceable to mankind.

It is true, one of man's faithfullest companions, the dog, is of carnivorous extraction; it is also, and most suggestively true, that the less carnivorous he becomes while in association with man, the safer and more companionable he becomes. The modern Anglo-Saxon, at least, feels lost without his meat three times a day, and accepts unquestioningly the tradition that without meat there is no appreciable strength. He does not stop to realize that in so far as physical strength is concerned, the bulk of the world's work has been done by those into whose dietaries meat scarcely ever enters. The domestic animals whose strength has been utilized by mankind, and who are accepted for companionship and noted for trustworthiness, gentleness and intelligence, obtain their nitrogen, not from meats, but from grains and grasses. Neither do they realize that a not inconsiderable part of the wisdom of the world, including all its religions, have come to us from the ascetic, vegetarian East. An argument long held unanswerable has been that meat, and meat alone, could nourish fighting men. In point of fact, a very considerable amount of very convincing fighting has been done by the potato-bred Irishman and the oatmeal-bred Scotchman. And it is noticeable that since the late unpleasantness between Russia and Japan, the advocates of a flesh diet as a winner of victories have done far less talking and more thinking. Add to these considerations the savory revelations incident to the beef-trust investigations; add, also, the enormous economic gain, could the poorer classes be convinced by precept and example, that health could be preserved and the palate satisfied without the relatively enormous cost of a meat diet. Finally consider how, in the opinion of high authorities, it is assumed that the large consumption of nitrogenous food very frequently leads up to the rheumatic diathesis, or troubles of the rheumatoid variety. We need not discuss the relationship of uræa, uric acid, etc., to the rheumatic difficulties, but it is easily demonstrable that in diabetics who are living largely or wholly upon a nitrogenous diet, the elimination of uric acid and urates becomes excessive, and very promptly indeed, difficulties of a so-called rheumatic nature develop. The direct etiological influence of a meat diet may not always be so easy to prove, but I am strongly inclined to think that many cases of flatulent dyspepsia, of palpitation, of headache, of neurasthenia and rheumatic troubles are due to this dietetic habit alone; and are frequently enormously benefited by its cessation. Surely, these considerations should lead us to experiment with other forms of proteid than flesh food.

There are certain popular views connected with *fats* with which I have never been able to sympathize. That they are greasy, must be admitted; but that they are unwholesome, I do not believe. The great care with which fats have been excluded from the diet of children during the past two or three generations has been, to my mind, an incalculable misfortune, and has had very much to do with the establishment of a common neurotic temperament so characteristic

of the present age. The abhorrence of many children to anything in the nature of fat would be amusing if it were not so disastrous.

I have known parents to hire their children for so much a week not to eat butter. We all know people who with scrupulous care cut all the fat from the meat which is served to them. We often hear people deprecating the use of fats, on the ground that fats are objectionable foods; but I have never yet heard a good reason given for this superstitious distaste. Fats are the foods above all others demanded by the nervous system. Fats are the best fuel food we have; and there is every good reason—indeed, a most demonstrable reason—why, in the cooler weather, particularly, they should be used much more generously than is usually the case. It is necessary to keep the body temperature up to about 98½° F., and a liberal supply of fat food renders this an easy task.

I have never been able to convince myself that the liberal ingestion of fat food disturbed the functions of the liver in the least. It is not a difficult task to prove that after being saponified and emulifield, fats are absorbed through the intestinal villi, carried to the lacteals, whence they make their way to the receptaculum chyle, and so on into the blood stream. The result of their combustion is heat, with carbon dioxide and water, which are easily eliminated. So that at no time in their physiological history do fats tax the liver. The carbo-hydrates, on the other hand, in the process of digestion pass through the portal circulation to the liver, and in all probability much of the billiousness that is complained of is due more to the carbo-hydrates, especially sugars, than to fats. It has been my custom for many years past to use very freely, in neurasthenic cases particularly, fat food, especially milk, cream, butter bacon, glycerine and cod liver oil. Olive oil and petroleum oils are, I think, in no way substitutes for cod liver oil, except possibly as to palatability. You will note that exclusive of cod liver oil—and that, by the way, will lose its terrors if followed by a pungent and inexpensive peppermint—I have mentioned several forms in which fats can minister to the palate as well as to the upbuilding of the system in general. Few will object to a liberal use of cream. Butter scotch, made with pure butter, is a valuable form of fat with which to lure infancy to the paths of health.

I have spoken of the elements of proteid and of fat, as factors in our dietary. Now, let us for a moment discuss the factor of sugar.

Ours is verily a land flowing with milk and honey. We are justly considered a prosperous nation. Our prosperity shows itself in the luxuries which we find easily obtainable. Among the edible luxuries sweets occupy a position in the front rank. The figures for 1906 are not obtainable, but the reports for 1905 show that there was imported into this country in that year nearly double the amount of sugar that was imported in 1898; $78,000,000 worth being the value of sugar imported in 1898, and $151,000,000 the value of that imported in 1905. That is, the quantity was less than 3,250,000,000 pounds in 1898 against 5,000,000,000 pounds in 1905. This does not

take into account, of course, the amount of sugar manufactured in this country, which is very considerable. Reckoning only with the imported sugar, and taking our population as being 80,000,000, it is fair to claim that the per capita amount used in 1905 was over sixty pounds. Assuming that the total amount of maple, cane, and beet sugar manufactured in the country only equalled the amount imported, and we have a per capita consumption of about 125 pounds per annum. Considering the fact that quite a percentage of the population consists of infants who are not eating sugar, and considering the large number of people too poor to buy it in any considerable quantity, it is probably quite within bounds to claim that those who eat sugar at all freely, use from 150 to 200 pounds a year. Is this large consumption of sugar justifiable on physiological grounds? Is manufactured sugar a wholesome article of diet? I think both these questions may be answered with an emphatic negative. It seems to me the white sugar now universally used is the most artificial form of food stuff made use of at all. Nature has given us some excessively sweet articles of food, among which honey and thoroughly ripe persimmons may be mentioned. But white sugar must be looked upon as one of the products of modern civilization, and therefore to be strictly questioned before we give it right of way to our tables. We readily admit that Nature has indicated very positively, indeed, the utilization and necessity of sugar as a food. In human milk, for instance, we get about seven per cent. of sugar, although it is not a very sweet product. In cow's milk we get on an average four and three-tenths per cent. It should be noted, however, that in these typical articles of food there is no starch; and that during digestion, starchy foods are converted into sugar, thus greatly minimizing the necessity for sugar with those who use starchy foods. Nature has also put into our fruits and berries, into certain vegetables and grains, a percentage of sugar, thus indicating that grape sugar and cane sugar, or milk sugar should form a definite proportion of our diet. If in this case, as in so many others, we could adhere closely to Nature's indications, and follow her guidance, it would doubtless be to the good of mankind. But man has taken a juice containing only two to five per cent. of sugar, and has crystalized this sugar by evaporation. The product, though sweet enough to suit almost any palate, is considered unsightly, and so it has to go through a very complicated chemical process for bleaching and re-crystalization; a process which probably intensifies its injurious properties. The final product is, as we all know, generously partaken of in the form of confectionery, by other and nominally wiser beings than the matinée girl; and it is also added freely to foods which Nature has already sweetened to her own ideas of what is right and proper for mankind.

The physiological chemistry of starch and sugar absorption and digestion is too abstruse and complicated for us to enter into to-night, but we may summarize by saying that Nature has indicated sugar to be a necessity in our diet, but that the modern, civi-

lized, well-to-do individual would do well to study and to be guided by the proportion of sugar that Nature employs. Otherwise, in this direction, even more surely than in that of any other dietetic error, except meat-eating, he pays for a flattered palate by disorganization of much more vital parts of his fleshy tabernacle.

We turn now to that very important division of dietetics which has to do with starchy foods, and with cereals. Among our many characterizations we have been called a "breakfast-food nation." Many people in our own midst, as well as among our neighbors, are wont to speak rather flippantly of cereals and breakfast foods. We are all familiar with the old passage of words between the Englishman and the Scotchman concerning the dietetic value of oats. "Oats," said the Englishman, "in England are food for horses; in Scotland, for men!" "Ahweel," said the Scotchman, "an' whaur find ye such horses—or such men?"

Oats are, indeed, food for horses; but they certainly have helped to make men worth reckoning with—or so it is claimed by the nation to whom it has pleased God to give a verra guid conceit o' themselves.

It has long seemed to me reasonable to look upon grains as among the cleanest and most wholesome of foods. They are relatively none of them perishable, and they are easily transported. There is something worth pondering upon in the somewhat terrible vitality of a food stuff which can quicken, and bring forth "fruit after its kind," after biding for two thousand years in the cerements of a mummy. Grains are not in need of "cold storage" or other dangerous methods of preservation. They are the product of a wise and beneficent Nature, whose experience covers a very much longer period of time than man's, and who evidently evolved in these grains a very high type of food. It is true that in common with the vegetables, they contain a good deal of indigestible cellulose; but they also contain a large proportion of starch, gluten, and more or less sugar. Some of them offer quite a percentage of fat, and an appreciable proportion of the chemical salts necessary to nourish living bodies. Containing so much that is necessary to maintain a vigorous bodily condition and promote sound health, why should the use of such foods be limited to breakfasts?

Let me pause to remark that there is something rather droll, rather puerile, and not a little irritating, in that slavery to dietetic conventions which dictates not only that we shall eat three times daily, "without the natural cause," as the song says, but that we shall eat only certain sorts of things at each of these three sacrificial occasions; dinner dishes being exactly the same in make-up, for instance, whether dinner be eaten at noontime or at night. Alleged rational beings would do well to rebel against this arbitrary folly, and establish a regime, under which food is to be partaken of when it is needed, and in no larger quantities than it is needed, and of such constituents as are needed. The cook has a word to say, you

urge? The cook be ——be spared a great deal of unnecessary labor by reasonable simplification of our diet!

It is in connection with one of the most useful of the grains that man has committed one of his greatest follies. I do not know who invented white flour, but I suspect it to have been that unnamable person who invented corsets and bridge whist; for it seems to me the invention was no inspiration born of knowledge or beneficence. Nature, after countless years of experimenting, produced a wonderful and salutary combination of elements known as wheat. From this, by an ingenious and mischievous series of processes, man has abstracted certain constituents, chiefly starchy principles, and has produced a white and pretty, and comparatively worthless substance that can be made into various ornamental, palate-tempting and dyspepsia-inciting combinations. Has man really improved on Nature in this instance? I am inclined to think not. Man rarely does. It is one of the ironic jests to be noted in this connection that having thus largely devitalized his wheat, in order to get a sufficient diet, man has to add to his bread butter, meats, and chemical salts. And even so, he does not get the full ration Nature has originally provided in her wheat. To parallel the figure man must cut in the eyes of Nature in so doing, one must recall the infant who plucks a feather from one molasses-smeared finger to stick it on another.

It is claimed that man's intestinal tract is not adapted to the digestion of vegetables and grains until these have been pre-digested by cooking. This, however, cannot be urged as a valid reason for not using them. Why should we not cook our grains and our vegetables? Animals—that is, the ruminant animals, allow vegetables and grains to remain in a pouch in which they are subjected to the action of heat and moisture, for a certain length of time before they are passed on into those parts of the gastro-intestinal tract where what is ordinarily called digestion really occurs. I am not in favor of the modern numerous ready-to-eat foods that need only a minute's cooking, or the simple addition of water. Commercialism has found the preparation of grains a lucrative field to work in, and has filled the market with products, some of which are doubtless useful, but the great majority, if not all of which, are practically unnecessary. They are no improvement over Nature's own product, and are more expensive.

I am strongly inclined to think that the free use of the whole grain, properly prepared by cooking, would be one of the most effective agents toward overcoming the very common tendency to constipation and sluggishness of the bowels, with all their attendant evils, which may be looked upon as among the unhappy pathological characteristics of our nation. This would mean, economically, the saving of the millions of dollars a year not spent on laxative and cathartic medicines, and the saving of thousands of lives lost by too intimate and prolonged acquaintance with such

medicines. It would interfere, of course, with the manufacture of "ethically and unethically" prepared "cures" for constipation. It would interfere also somewhat with the sale of saline and other spring waters miraculously discovered by Indians. But it would prove an unmixed blessing to an over-fed and under-nourished race.

Possibly what I have said will strike you as bearing chiefly on the condemnatory and negative side of things. If time permitted, I could speak positively and favorably enough of many articles of food. Time does not permit me to outline in detail a menu for a week, or even for a day. I can only suggest that you compound for yourselves and try, before you prescribe it, a diet list that includes in well-studied and palatable combinations, milk, cream, butter, eggs, cheese, nuts, possibly fish, and the entire list of grains, vegetables and fruits. I believe you would find only good to result from such experimentation; and good in such proportion as would fill you with gratified amazement. You say, perhaps, that from such a dietary your patients could not consume anything like the bulk of their present food. Probably not. That would be among its chiefest benefits. Believe me, they would consume all they need to maintain sound and lasting health; and that health would lend to the simplest diet a relish that is too often lacking to their present irrational and—I say it deliberately—unclean dietary. We should not waste time wrangling over objective detail, in any subject under discussion, if we went oftener to its underlying basic principles. One basic principle of Nature, in dealing with man, is "to bribe him," as Mrs. Steele pithily puts it, "with agreeable sensation, to the discharge of certain duties vital to his own well-being, and that of his race." The wise man enjoys those sensations only in conscious and direct association with the discharge of those duties. In the instance now under consideration he eats what will best repair the waste of his protoplasm; and he thankfully accepts Nature's unfailing bribe of pleasure in eating. The unwise man eats to multiply, intensify and prolong sensation, to the detriment of the purpose of eating; that is, he disorganizes his protoplasm, instead of ministering to it. He and his fellows of other fields of physical duty and sensation learn, and not slowly, that Nature has other basic principles on which she deals with those who prostitute her uses and abuse her rewards.

THE TREATMENT OF ACUTE INFECTIOUS DISEASES.

WILLIAM C. GOODNO, M. D.,
PHILADELPHIA, PA.

When your President honored me with an invitation to attend this meeting and gave me the privilege of offering you anything my little storehouse might contain, I cast about to find some subject worthy of the occasion. As several passed in review, I decided against one after the other for various reasons, but mainly because each appealed to a portion only of the medical profession. I decided finally to follow a rule I established for myself years ago, viz., to select such subjects for the consideration of large bodies of practitioners as possess features of clinical interest to the majority of those who listen to me. I have selected for this evening's consideration a very practical subject of this character with the thought that, after all, in this era of investigation so often instituted for pathological or bacteriological results only, the most valuable contribution one can make to the doctor who, morning, noon and evening, and often all the night through, is worrying his brain and wearing out unduly his body, to find some source of relief and cure for his sorely distressed patients, is some bit of practice or reasoning which will really help him, or direct his mind into lines of thought which will enable him to search out help for himself.

With this object in view, I invite your attention to "The Treatment of Acute Infectious Disease," with particular reference to some experiences in the use of phenol in the treatment of infections.

In the present state of medical science one of three methods of combating disease is employed. First, by the homeopathic remedy; second, by what in common parlance is called "old school" treatment; that is, meeting the various conditions and symptoms developed by a disease process by the use of drugs which antagonize them. For instance, the use of morphine for the control of pain, diuretics for renal inadequacy and expectorants for difficult expectoration, are examples of such an application of drugs. But further, based upon theories of disease, or a positive knowledge of its pathology, the physiological action of drugs is often employed to secure certain effects; for instance, the administration of chloride of calcium for hemorrhage, which it is supposed to influence through its power of increasing blood coagulation. An explanation of the *modus operandi* of certain remedies, such as iodide of potash in the treatment of constitutional syphilis, has not yet been explained. Third, through the use of certain anti-toxic serums, or of drugs exhibited for their anti-bacterial and anti-toxic influences.

As to the first method, that by the homeopathic remedy. We

know that it possesses value. How it acts is yet a matter of conjecture. Perhaps, as Dr. Herbert Moore suggests, it may be explained by the "side chain" theory of Ehrlich; but however it acts, it seems certain that it in some way increases the defensive power of the body. While its use modifies, and possibly in some instances shortens, infectious illness and lessens mortality, we cannot claim such successful results as follow the use of anti-bacterial and anti-toxic agents in the forms of disease for which they have been successfully developed, notably in diphtheria. Of late, most effort has been in the direction of the development of anti-toxic serums, but the development of effective anti-toxins has been beset with much greater difficulties than it was at first supposed would be the case. In considerable measure this has been due to the fact that clinical entities we call by certain names, *e. g.*, influenza, pneumonia, etc., are due to the combined action of two or more micro-organisms. One form seems to be specific to the disease, and the others act by virtue of its presence as well as of the pathological changes it has excited. Clifford Allbut has graphically expressed the combined action of micro-organisms, as related to influenza, as "the conspiracies of influenza," referring to the ready association of the Pfieffer bacillus with that of pneumonia or of tuberculosis, or with some of the cocci, giving rise to occasional complicated cases, or to peculiar mixed infections, such as have frequently occurred in the form of local epidemics, and presenting correspondingly peculiar clinical characters. Presslich last year reported such an epidemic occurring in Vienna. He personally examined 154 cases, and points out the higher mortality and longer duration (32.7 days against 4–6 days in the pandemic of 1889–90). In the 154 cases there were 15 pneumonias, 16 pleurisies, 8 cases of endocarditis, 7 cases of tuberculosis (rekindled activity, probably) and 5 cases of otitis media.

It is some five or six years since I observed in a medical journal, or some annual of medical science, the statement that two French observers had demonstrated that phenol could be given in what had been heretofore considered to be very large or even poisonous doses, if the agent were perfectly pure and had undergone no decomposition, and that the disturbing influence sometimes observed from the use of this agent was due to impurities, mainly of decomposition. These experimenters gave phenol in quantities as great as three hundred grains *per diem* without the development of disturbing or poisonous symptoms. I have a most distinct recollection of these facts, but in spite of quite a search made during the preparation of this paper, I was unable to find the original. This is of small importance, however, and I have mentioned these observations only for the purpose of indicating what first led me to commence the therapeutic investigations I shall present to you. My first thought was that a small portion of the three hundred grains of phenol which it had been shown could be administered in one day without bad

results to the healthy, might exercise a sufficient influence upon the growth of parasitic forms of life within the human body, and especially upon their toxins, to arrest or modify infectious disease. I accordingly commenced its employment in a variety of infectious diseases. I have steadily persisted in the investigation with, to me, increasing evidence of the great value of this agent in the treatment of a considerable variety of infections, especially of an acute character. For this purpose I have employed the absolute phenol of Merck exclusively. It is furnished in the form of fine white crystals which, if free from decomposition, yield with glycerine and water as a solvent, a perfectly colorless solution. Crystals, no matter how white and pure looking, have been discarded if the solution exhibited any degree of pink color. It is not uncommon for original packages of these crystals to give a decidedly pinkish color when dissolved, the package having been kept in stock too long. As a rule, fresh crystals will keep for several months after they are procured from the dealer, if they are kept in amber bottles and in a dark closet. They are several months older, however, this time being represented by the period intervening between their manufacture and their delivery by the local dealer. Solutions varying from two to five per cent. are convenient for use. They should be kept, like the crystals, in amber bottles and in a dark closet. If doses of three to five grains are given by the stomach, they are best administered in six ounces of water and preferably after food. If taken on an empty stomach, phenol sometimes produces head symptoms similar to those caused by quinine. Doses of one or two grains never annoy. Some of the finest results from the use of phenol follow its hypodermic use. This applies to both acute and chronic forms of disease. In young and middle-aged subjects the five per cent. solution is a satisfactory concentration, but in old persons in whom the blood vessels and tissues are not in good condition, phenol had best be used cautiously, especially when injected into the lower extremities. I have not, however, observed any unpleasant results from the injection of phenol many hundreds of times, but as slight injury, either of a chemical or mechanical nature, may cause necrosis in patients of this class, it is wiser to exercise care in its employment. In the old I have not used solutions stronger than one per cent. hypodermatically, and often weaker. It is quite possible that in many cases injections given at some indifferent point may act quite as well as at the location of the pathological changes, but in most cases I have made the injections, as in rheumatism, at the points of pathological change. If the skin is raised between the forefinger and thumb and pinched a little, while a point of ice is applied firmly for a minute or two the needle puncture is scarcely felt. When several injections are to be made at one time, this little precaution saves the patient considerable pain. Being a local anæsthetic, the phenol quickly removes any discomfort caused by the injection. While I have frequently

employed forty to sixty grains of the acid in a day, I have never observed "carboluria" or other evidence of poisonous action, with one possible exception. Recently, Dr. Killian, one of our internes at Hahnemann Hospital, Philadelphia, asked my advice respecting a sharp attack of influenza which was attended by fever and active catarrhal symptoms. I suggested five-grain doses of phenol after each meal. Some days later, as I left the city immediately after seeing the doctor, he informed me that his grip "slumped" at once, but that his urine became dark, as if containing coffee, about forty-eight hours after commencing the phenol, but that this color soon disappeared. I was suspicious that the condition was due to irritation of the kidneys, but as no analysis of the urine was made, this could not be determined. Without my knowledge, however, the doctor took upon himself to experiment with the drug, taking it in five-grain doses, as before, and continuing it for over two weeks without any change of color taking place in his urine, or any disturbance of the kidneys. This was corroborated by analysis. In ordinary doses, up to ten or fifteen grains *per diem*, phenol appears to stimulate rather than depress. In such doses it acts, possibly, as a medullary stimulant, raising the vascular tension. The opinion, which seems to be quite general, that the dark color of the urine often observed in phenol poisoning is due to blood, and is an indication of renal degeneration, is without support. Recent pharmological investigations show that the smoky tint of the urine is not due to blood, but to the presence of the phenol which is excreted mostly as phenyl sulphuric acid. (O. SO OH.) A portion is also excreted in combination with glycoronic acid, and still less is partially oxidized to pyrocatechin and hydroquinone. These bodies give to the urine its smoky tint. Oxidation increases on standing, with the result that the color gradually darkens. That phenol may, however, cause nephritis, especially if the kidneys are already defective, is undoubted, but only when taken in poisonous quantities.

My first trial of phenol, excepting my long-time use of it in scarlet fever, was in the management of influenza. At first it was administered only to typical cases of the disease; *i. e.*, those accompanied by fever, catarrhal symptoms, etc. Later I employed it in the treatment of what we commonly call colds, but who can draw the line of demarcation between these two groups, unless the microscope is employed? and even this does not separate them clinically, for we have learned that true influenza may exist in an exceedingly mild or in a chronic form. For well-developed grip in the adult, five grains of phenol should be given in six ounces of water after each meal, and be continued for one or two days, according to the severity of the attack, after which half doses had best be continued until the patient fully recovers. In most instances there is evident control of the disease within twenty-four hours.

In many cases the temperature does not rise above normal, or but slightly so upon the second day, and much less frequently so

on the third day. Indeed, the disease generally slumps, as Dr. Killian expressed it, as soon as the patient comes fully under the influence of the drug. No other remedy is required to help out, as the phenol strikes at the very essence of the disease, and all of the results of its action subside and disappear. Most important of all, there is, in cases treated by phenol, an almost complete absence of the prostration so frequently and markedly developed in association with influenza. The bronchitis is very positively influenced. In some cases in which the phenol has been discontinued too soon, or has been administered in too small doses, with the result of an increase of the patient's symptoms, especially of a bronchial character, full doses have given prompt relief.

Against ordinary "colds" characterized by rhinitis or bronchitis, or catarrh of the whole respiratory tract, phenol is an effective remedy.

During the past month influenza has been quite epidemic in Philadelphia. Many of the cases have been of a severe type. I had an opportunity to study a "house epidemic" in my own home. My mother and sister, who were visiting me, were the first victims.

Case I. A feeble old lady of 86. First day, slight chill followed by a temperature of 101.2° General pains, cough and prostration. Phenol grains V. t. i. d. Second day, temperature 99.1° All symptoms diminished. Phenol in half doses was continued for two days longer, then stopped. Improvement apparently continued until on the sixth day cough developed during the night; was quite troublesome and attended by much loose rattling in the bronchi. Phenol grains V. t. i. d. Seventh day, cough much lessened. The cough continued to diminish from day to day, and was entirely controlled by the tenth day. There was very little feebleness sequential to the attack.

Case II. A woman of 60. First day, no chill, temperature rose to 102.3°. General pains, especially headache. Much cough. Feels very miserable. Phenol grains V. t. i. d. Second day, temperature 100° Cough less in frequency, but much loose rattling and expectoration. Feels better generally. Third day, temperature normal. Cough and expectoration less. Fourth day, temperature normal. All symptoms rapidly diminishing. Continued phenol, in gradually diminishing doses, for five days. Debility was slight, and quickly disappeared.

Case III. Colored butler of 60. Felt ill for twenty-four hours before reporting, when he looked quite prostrated. When first examined, upon the second day, his temperature was 103.4° Cough frequent and dry. Respirations 30, pulse 130, complete anorexia and heavily coated tongue. Phenol grains V. t. i. d. Third day (second of observation), temperature normal in the morning with a rise to 100° in the evening. All symptoms relieved. Continued phenol in full doses. No return of any active symptoms. Felt weak for a few days only.

Case IV. Chambermaid. First day, slight chilliness, tempera-

ture 100.3°, is sweating and feels weak. Slight cough. Phenol grains X given at once. Phenol continued in doses of grains V. t. i. d. All symptoms disappeared in twenty-four hours.

Scarlet Fever.—It is now fully twenty-five years since Wiggelsworth of England commenced the use of phenol in the treatment of scarlet fever. During this long period he has published a number of striking papers upon the subject, but they do not seem to have received the consideration they merit. Not only does he conclude that his control of this disease by means of phenol has been much more satisfactory than by other methods, but that children infected by those who have been treated by phenol develop the disease in a mild form. Viewed from a bacteriological standpoint, this is entirely possible. As for a dozen years past I have seen out-patients only with other practitioners, my opportunities for observing scarlet fever cases before they have become thoroughly poisoned has been limited during this period. For several years previously, however, I made an occasional use of the phenol in the treatment of scarlet fever cases, when seen in the early stage, and was much impressed by the results. This experience was sufficient to incline me to believe that Wiggelsworth's contentions were probably correct.

Judging by the great frequency of the violation of the most important principle underlying the treatment of infections, it is impossible to reiterate too often that in order to the successful antitoxic treatment of infectious disease in any form, it is essential that the agent used for this purpose shall be administered at the earliest stage of development of the disease; *i. e.*, before the pathological changes in the blood and tissue are developed in any considerable degree. The blood and tissue mischief which leads to the alarming manifestations of any form of infection are, unfortunately, already present while the patient is still free from symptoms exciting apprehension. When this fact shall be generally recognized and acted upon in practice, the mortality from this great and unnecessarily prevalent group of diseases will be strikingly lowered.

Pneumonia.—As yet, my employment of phenol in the treatment of pneumonic fever has been small, largely for the reason that other agents first claimed my attention as possible remedies for this form of infection, and life—and consequently experience—are altogether too limited to permit trial of a great variety. Those cases I have treated with it have been, in the main, pneumonias developing in connection with influenza. Usually influenzas which have run for days without the phenol treatment, and in which a complicating pneumonia has not been made out certainly at the time of prescribing the drug. While preparing this paper I saw a large, gouty woman, 64 years of age, whom I had previously treated in my office for a large, feeble, arrythmic heart, without evidence of valvular disease, who had developed influenza with typical symptoms. Upon my first visit I found her temperature 102.8°. Respirations 28. Much cough, with muco-purulent expectoration and

multitudes of small moist rales all over the bases of both lungs. There was severe pain in right lower chest, quite constant, but much aggravated by breathing and moving. I could not make out the definite signs of pneumonia, but as she had had previously two attacks of gouty neuritis, once in the arm and the second time in one of the lumbo-abdominal nerves, I at first suspected the pain might be due to a recurrence of this affection. She received phenol grains V. t. i. d. There was prompt improvement in most of her symptoms. After two days, however, the presence of pneumonia was easily determined by the physical signs, but as the respiration had but slightly increased and the general condition was improved, I continued the phenol. There was no further increase in the severity of the symptoms but, indeed, a rapid diminution. Considering the character of the subject of this attack, the result was a surprise to me.

Erysipelas.—For many years I have, like many others, employed phenol in weak solutions as a remedy for erysipelas. It must be twenty years since I first published cases treated in this manner. Of late years much better results have followed the use of stronger solutions, but, as in the anti-toxic treatment of any form of infection, the treatment must be instituted early if the best results are to be secured. The best plan of procedure is, if a hairy surface is to be treated, to clip or shave the hair to well beyond the involved surface. Apply hot fomentations for fifteen minutes, then quickly dry and paint the inflamed area well beyond the lesion with the phenol, which is to be liquified by warmth and a very small quantity of glycerine and water. Within a few minutes the surface becomes white and shriveled like a washer-woman's fingers. When this condition is well marked, the action of the phenol is to be neutralized by 95% alcohol applied upon pledgets of cotton, with due care to prevent spread over too much of the sound skin. As the most active growth of the streptococcus is taking place in the lymph channels at and beyond the periphereal edges of the inflamed area, the application must be made with especial care at and beyond the edges of the lesion. In my hands this method has not once failed to arrest the process promptly if applied before the inflammation has been extensive and the toxæmia virulent. I have occasionally made a second and even a third application, but this must be seldom necessary.

If you will pardon the degression, I will refer to the use of phenol in neuritis. My experience with phenol in the treatment of neuritis has been recent and not large, but most encouraging. The last case consulted me on January 21st. This patient was a lady of 36 who had been much impaired in health for several years. She was attacked very suddenly in the early morning with intense pain in the left arm. Within a few hours the pain extended from the point of onset, about the middle of the arm, down the forearm and into the hand, especially into the thumb. There was every evidence

that the pain was violent. There was tenderness of the whole painful area, but especially marked along the main nerve trunks in the arm. I injected one grain of phenol in 30 minims of water and glycerine. This was followed by a peculiar "prickling" sensation throughout the entire limb. All spontaneous pain ceased within an hour. On January 23d a second injection was made near the first one, and a third injection upon the 24th. The second injection was given because of slight return of pain. The third one, however, was probably unnecessary. During the previous night the patient had awakened with pain, and found she had her arm under her head. The pain caused was not great, and was decreasing when I saw the patient, but she insisted upon having the injection. The arm and forearm remained a little tender, and felt, to use the patient's expression, like a "sick baby" for a full week; but there was no return of pain, although up to the tenth day the patient complained that the limb seemed to her hard and swollen. Neither measurements nor touch confirmed this view of the patient.

A gentleman who was spending last summer in Germany was attacked with neuritis of one of the lower right intercostals. He was treated by German physicians for several weeks without results, and arrived in Philadelphia October 20th unimproved. One injection of two grains of phenol placed within the most tender focus was followed by almost instant relief. There was no return of pain.

Rheumatism.—During the past year I have treated all my cases of rheumatic fever in the wards of Hahnemann Hospital by means of phenol. The results have been quite surprising to a considerable number of physicians who have observed the cases. The average rheumatic fever is arrested and cured by phenol in a most spectacular manner. My method has consisted of daily injections of the phenol near or over the affected joints. The quantity of the drug injected has varied from one to two grains. The treatment has been continued until all acute symptoms have completely subsided. Several cases developing endo and pericarditis have received additional injections over the heart. In every instance the cardiac inflammation has subsided and the patients have been discharged with normal hearts. Regardless of the severity of the case, the pain has, as a rule, been controlled within twenty-four hours, and has disappeared within two or three days. In none of the patients treated has there been a return of the disease after its first control. Notwithstanding this, we have kept our patients in bed for at least a week. Persons admitted with advanced attacks require more time for both relief and cure. Those who have had repeated attacks declared that they have never experienced such rapid results before; indeed, the relief has been so remarkable in its rapid development that patients have watched their cases with marked evidence of interest. I have experimented with salicylate of sodium and a variety of remedies, hypodermatically, for several years past, but have found no remedy to compare in efficiency with the phenol. At first I feared that chronic arthritis would not respond to this treat-

ment and, consequently, did not try it in such cases; but in this I was wrong, and Bartlett first showed me what it would accomplish for this class of cases. The first case of chronic polyarthritis I employed it for was under the care of Dr. Chas. H. Conover of Philadelphia. This man has been a sufferer from the disease for three years. During the past year he has not only been incapacitated from labor of the lightest kind, but has been bedridden and taking large doses of narcotics at night for the relief of his terrible suffering and sleeplessness. The patient had had full benefit of most careful homeopathic prescribing for a long time before the doctor, for pure humanity's sake, was forced to relieve his suffering. Dr. Conover came to see me in relation to the case, and after describing his sufferings said, "for God's sake tell me something to relieve this poor man; I am ready for anything." I suggested phenol. It was injected near each principally affected joint once daily. After two groups of injections no more morphine was required. After eleven groups, administered in as many days, the man walked out of doors and has been steadily improving since. In a long-standing case of this character, in which much joint mischief has taken place, anatomical recovery can hardly prove perfect. A number of other cases of chronic rheumatism have now been treated by the phenol method, and I can commend it to you most earnestly.

In my endeavor to avoid a long paper I have treated the subject very superficially, I am afraid, but hope that enough has been stated to enable those who care to adopt the method to put into operation a treatment which will afford them much satisfaction. It is not a method which can be employed successfully by the originator only, but by any doctor who has arrived at that point in experience at which he realizes that no matter how simple a therapeutic method may appear to be, it must be mixed with brains in order to obtain the best results.

NERVOUS DYSPEPSIA.

GEORGE F. LAIDLAW, M. D.,
NEW YORK CITY.

Several years ago, a young woman 30 years of age was referred to me for relief of a pain in the stomach that appeared regularly two hours after eating and also at 6 A. M. There was no vomiting, no regurgitation, very little gas and the bowels were regular. The pain had persisted for eight months without relief from the several forms of diet and remedies prescribed. On examination, I found normal heart and lungs, liver and spleen of normal size, no tender-

ness over the gall bladder or appendix, the kidneys in place, the lower border of the stomach one finger-breadth above the umbilicus, and the gastric juice, after an Ewald test breakfast, normal.

The history threw some light on the matter. Here was a previously healthy young woman who had grown up in luxury and leisure, whose father had died eight months before, leaving the family with absolutely no resources. Besides the shock of her father's death, the girl had been obliged to take up the wholly unaccustomed work of a commercial position. The gastric distress had appeared shortly after the father's death. The patient had been treated by physicians of different schools without success, and she had been referred to me as a suspected case of gastric ulcer. My provisional diagnosis was nervous dyspepsia, to be confirmed by the results of treatment. My first and second prescriptions of calcium chloride and the Durande mixture of ether and turpentine gave some relief, but there were frequent recurrences of the pain. Studying the case anew, I concluded that the causal factor of grief should be an important element in the prescription. This, with the associated sleeplessness, indicated the use of ignatia, of which I gave five drops of the tincture after meals, to be persisted in for one month. Rapid relief and ultimate perfect cure was the result.

There are several points in this history which marked the case as a typical nervous dyspepsia. First, the appearance of the trouble in a previously healthy woman after a domestic sorrow. Secondly, the absence of evidence of organic change in the stomach or other organs which could explain the gastric pain. Thirdly, the prompt curative effect of a neurotic drug like ignatia. If I had known then as much about nervous dyspepsia as I do now, I would have begun with ignatia, instead of wasting time with remedies like calcium chloride and the Durande mixture, which are better adapted to pathological changes in the gastric mucous membrane.

Hear another history. A man aged 55 years, subject all his life to constipation, otherwise strong and athletic, complains of belching of gas from the stomach with the tasting of food, occurring from two to four hours after meals. The belching is worse after breakfast, worse after exercise, better from rest and in the evening. Examination shows normal heart, lungs and spine, normal abdomen and normal urine. The lower border of the stomach is two finger-breadths above the umbilicus. The test breakfast shows a high percentage of hydrochloric acid, but still within normal limits. Note this important point in the history. The trouble began shortly after the death of his son and the consequent serious illness of his wife. Here we have two of the three requisites for the diagnosis of nervous dyspepsia, psychic shock in the beginning and the absence of recognizable pathological changes in the internal organs. There remains the third confirmatory symptom of improvement under a distinctly neurotic medicine, which is supplied by his prompt relief from the use of five-drop doses of the tincture of nux vomica after meals, prescribed on the symptoms of persistent con-

stipation, marked relief of all symptoms when the bowels moved, aggravation from sour foods as well as on the gastric symptoms. It is noteworthy that this patient had already taken nux in potency without relief.

Here is another typical history. A musician, aged 30, for one year had had pain in the epigastrium from one-half to one hour after eating, the kind of food making no difference. There was no vomiting, nor regurgitation. Examination showed normal heart, lungs and abdominal viscera, no tenderness over appendix or gall-bladder, normal spine, the lower border of the stomach two finger-breadths above the umbilicus, the test breakfast normal and the urine normal. The patient attributed the trouble to an acute indigestion following the eating of clam chowder ten years before, since which time he had been subject to prolonged sieges of abdominal pain. Here the element of initial nerve shock was lacking, but the patient was of that poorly-balanced, extremely sensitive type, so common in musicians, to which little things have the effect of big things on other men. His sensitive nerves were really subjected to many shocks in the course of an ordinary day. On the diagnosis of nervous dyspepsia, and in the absence of other marked symptoms, ignatia was prescribed. He had been dieted in all sorts of ways without relief. I advised general diet of plainly-cooked food of all kinds, only avoiding coffee and an excess of sugar. The attending physician tells me that the patient believes he gets more relief from ignatia than from any other medicine he has taken. I believe that in this case the use of an abdominal bandage will be necessary to complete the cure.

Consider now another group of cases, those combined with prolapse or dilatation of the stomach. A woman, 38 years of age, healthy in early life, ate ice cream on a very hot day, one year before I saw her. The next day she had an acute attack of indigestion, being swelled up with gas, but with no relief by belching and no severe pain. Before she recovered, her husband was taken sick, and for a long time she was much worried by domestic and financial cares. Since that time she has never recovered her former digestive comfort. The chief symptom is a fullness or dull pain that begins in the back about two hours after eating, and lasts until she eats again. Eating relieves for a time. Under the direction of a very capable physician, she has tried frequent eating, taking six meals a day, then hot water before meals, then hot water after meals, then cold water, then no water at all. There is no vomiting nor nausea, but there is bad taste in the mouth on waking. She sleeps well and the general strength is good, only she is afraid to eat for fear of starting the pain. This form of fear is a characteristic symptom of nervous dyspepsia, and it corresponds with the neurasthenic state on which nervous dyspepsia is based. The symptom is most marked in nervous dyspepsia and cancer. The attending physician referred this case to me for examination to determine the possible presence of malignant growth. On examination, I found the lungs

normal. There was a blowing systolic murmur in the carotid arteries, heard only when recumbent. The apex of the heart was in the fifth space, three and a half inches to the left of the median line. The liver and spleen were normal in size and position. The right kidney was movable, coming down to the iliac crest, and the lower border of the stomach extended three finger-breadths below the umbilicus. The abdominal wall was relaxed and pendulous. The urine was normal, and the Ewald breakfast showed a normal percentage of hydrochloric acid and a normal digestive activity of the gastric juice. A diagnosis was made of enteroptosis, including the prolapsed right kidney and dilatation of the stomach; arteriosclerosis involving the aortic valve, and dilatation and hypertrophy of the heart. The primary indication for treatment was to apply an abdominal bandage to hold the prolapsed abdominal organs up in place. This, with five drops of ignatia tincture after meals made such a rapid and astonishing improvement in the patient's condition that she shortly afterward sent to me a woman friend suffering from a stricture of the pylorus, on whom I was expected to perform a similar miracle. It is needless to add that, in the latter case, the miracle was not performed.

Another history is that of a woman of 35 years, who complains that all food eaten turns to gas in about half an hour. The gas presses on the heart, which beats hard and fast until she takes some medicine for it. Almost any medicine seems to relieve the attack. Inquiry reveals the familiar story of a previously healthy woman meeting domestic and financial losses, with a flatulent dyspepsia following hard upon; of a woman making her living as a teacher in a position involving much responsibility, and an attempt to stretch a moderate salary to cover a large family. On examination the heart and lungs are found normal and the liver and spleen normal. The lower border of the stomach is found below the umbilicus on the left side, reaching the level of the umbilicus in median line. The kidneys are in place. The urine and gastric juice are normal. A diagnosis is made of nervous dyspepsia with dilated stomach. The adoption of an hour's rest daily, lying down, the application of an abdominal supporter and the use of five drops of phosphoric acid three times daily gave prompt improvement. Of course, as long as the mental strain and anxiety continue, frequent relapses are to be expected.

The next case is a rather illuminating one. A woman aged 24 years had been subject all her life to frequent attacks of indigestion, taking the form of intense pain and the belching of enormous quantities of gas. She had also had various forms of muscular rheumatism and neuralgia. A peculiar feature of the case was the frequent changing from one form of disease to another. Within an hour or two she could have an intense indigestion with enormous quantities of gas, which would entirely disappear on the appearance of a neuralgia, and this in turn changing back to the indigestion or muscular rheumatism with lightning rapidity. She had been dieted for

many years and prescribed for by men of all shades of potency, including a very thorough student of symptomatology. It was a marked case of neurasthenia with the easy fatigue, spine sensitive to pressure, sensitiveness of all symptoms to changes of the weather and to mental attitudes that is characteristic of the neurasthenic. Examination revealed normal heart and lungs, normal blood, normal urine and abdominal organs normal, except the stomach, the lower border of which was level with the umbilicus. To my mind, there were several things to be done. For years her various physicians had denied this patient nearly all forms of starchy food, under the idea that the starch would ferment and increase the gas. The girl was thin, weak, irritable and under-fed, resembling a diabetic who had been deprived of starch for too long a time. The first point was to recognize the fact that the kind of food eaten had little or nothing to do with the gas produced. The second point was to recognize the prolapsed stomach and to hold it in place with an abdominal bandage. The third point was to recognize the neurotic nature of the indigestion, and prescribe a drug which acted on the digestive nervous apparatus. At first, I recommended general diet and the abdominal supporter, and as a medicine, my old friend, calcium chloride. There was marked temporary relief, but it was not until I used ignatia as a remedy that I came within sight of a real cure. The symptoms of this patient, by the way, were distinctly aggravated by drop doses of the tincture. Five-drop doses of the 3x dilution proved better adapted to her case.

Another case of this same type is that of a formerly healthy woman, aged 26 years. Eight months before I saw her, her mother had died suddenly while the patient was away from home. Directly after the funeral there appeared an intense pain in the left side of the chest, which came after eating. There was no belching, though there was a feeling as if belching would relieve. Under rest in bed and light diet, she had recovered sufficiently to return to work, but two months before my record begins the pain had returned. There was then a sharp pain which began, about three hours after eating, in the region of the left kidney, then moving around into the left hypochondrium and under the left breast. Here, too, there was the marked dread of eating for fear of bringing on the pain. On examination, the heart and lungs were found normal, the liver, spleen and kidneys normal, and there was no tenderness over the gall-bladder or the appendix. The spine was not sensitive to pressure. The lower border of the stomach extended two finger-breadths below the umbilicus. The test breakfast was normal, but there was a retention of a few food scraps beyond the normal time of emptying the stomach, showing impaired motility. A diagnosis was made of nervous dyspepsia and a dilated stomach. Rest, lying down for an hour before dinner, the application of an abdominal bandage, general diet and the use of ignatia were recommended, a course of treatment which has proved very satisfactory.

To those case histories I could add many more, illustrating the

various symptoms presented by nervous dyspepsia. There are the cases of nervous vomiting, which must be carefully distinguished from pyloric obstruction, and in the treatment of which my old favorite, calcium chloride, or the tincture of iodin are sovereign remedies. There are the cases presenting persistent tympanites and intestinal pain, which must be distinguished from appendicitis, renal colic and gall stone, in which belladonna is useful, often in the form of belladonna ointment rubbed into the skin of the abdomen. There are the cases with persistent nausea where every over-exertion or mental strain causes nausea, in which a prolapsed uterus or other genital lesion requires correction; and in which gelsemium does good work. There are the cases who are always relieved by taking food, in which anacardium is useful. Farrington pointed out that anacardium resembles nux vomica closely, and is sometimes successful where nux fails. There are the cases tending to diarrhœa on slight causes—which I have seen dieted until they were half starved—in which an abdominal bandage, general diet and cuprum or gelsemium made the cure.

I have attempted this panoramic review of case histories in order to bring before you more clearly my conception of our proper attitude toward the condition known as nervous dyspepsia. Nervous dyspepsia is not a disease. Like epilepsy, like cough, like dropsy, like peritonitis and like neurasthenia itself, it is only a symptom. The better we understand a disease, the more apt we are to attach an exact meaning to our words. The more exactly we define our words, the more apt we are to regard diseased conditions as symptoms, rather than as diseases themselves. A doctor's understanding of a disease depends on how successfully he can get behind the meaning of the word to the actual condition. This search for the actual cause and true nature of a disease is characteristic of the medical study of the past hundred years.

It was not many hundred years ago that the word "cough" expressed to the physician's mind a definite disease which was to be treated simply as a cough, and that was the end of it. There were the somewhat fanciful attempts to classify coughs as liver coughs, stomach coughs, spleen coughs, and the like; but it was not until the advent of the exact pathological studies of the early part of the nineteenth century and the development of the art of physical diagnosis, that physicians inquired more intelligently into the conditions that lay behind the cough. Was it laryngitis or bronchitis, or the cough of heart disease, or an invasion of tubercles? One hundred years ago dropsy was a disease to be treated as such. After the work of Bright upon the kidney, and of Traube and Skoda on the heart, we examined patients more carefully, and dropsy came to represent only a symptom of a heart disease, or a kidney disease, or a watery blood. It was not so long ago that you and I sat on benches at a medical college and heard lectures on peritonitis as a disease *per se*, with a therapeutics of its own. Which of you nowadays would think himself justified in diagnosing peritonitis and

treating it without trying to find and remove the cause, whether an appendical abscess or impacted gall-stone or suppurating tubes? Peritonitis is no longer a disease. It is only a symptom. It is just so with nervous dyspepsia. It is not so long ago that the word "dyspepsia" indicated a definite conception of disease. Then we learned that some dyspepsias were due to gastritis, some to cancer of the stomach, some to Bright's disease, some to heart disease, some to insufficient mastication and some to the use of irritating food. Nearly thirty years ago, Leube claimed recognition for another type of dyspepsia as a distinct disease—nervous dyspepsia—which was characterized by subjective distress attributed to the stomach, but without demonstrable changes in the stomach wall, its mucous membrane, its secretion or its motility. This conception of a pure sensory neurosis satisfied the medical mind for a time. Ten years later, Leube himself announced that while in nervous dyspepsia the extreme sensitiveness of the nervous system was the chief factor, we must admit the presence of slighter grades of motor and secretory gastric disturbance. We are now beginning to realize that nervous dyspepsia is only a symptom of a primary disease or cause concealed behind it. It is on the recognition of this underlying cause and its correction that your success in the treatment of nervous indigestion will depend. From the study of many cases, I am convinced that the pathological basis for the symptoms of nervous indigestion usually consists of impairment of gastric motility. My reason for so thinking is, in the first place, that the symptoms of a nervous dyspeptic are identical in form, and in their modalities of relief and aggravation, with the symptoms of undoubted dilatation of the stomach; and, secondly, because the most successful treatment of nervous dyspepsia is that which we apply with success to dilatation of the stomach. At other times there are changes in the composition of the gastric juice. Bear in mind that our tests both for gastric motility and the chemical composition of the gastric juice are still very crude, and that many slight departures from the normal probably escape our attention. Bear in mind, also, that the secretion of the juice and the gastric motility are exquisitely under the influence of the nervous system, and you will readily understand how the symptoms of nervous indigestion can be caused by mental emotion or such reflex causes as uterine displacements and eye-strain.

I would not be understood as saying that the cure of nervous dyspepsia is a simple matter. Far from it. Sometimes two or three months of patient treatment are required before both you and the patient are sure that you are on the right track. It is often a matter of great difficulty; so much so that all writers on diseases of the stomach caution against expecting too much from treatment, and dwell on the frequency of relapses. My own experience leads me to a more hopeful conclusion. I believe that a physician will be successful in the treatment of nervous dyspepsia in exact proportion to his mental equipment for the work, such mental equipment

consisting of a practical acquaintance with our best methods of testing the anatomical condition and function of every organ in the body, or the insight to see where the examination of a specialist will help him out. A distinguished German author wrote truthfully, if unwittingly, that these nervous dyspeptics with their chameleon-like and illogical changing from one group of symptoms to another, without an exact anatomical basis for treatment, are just the cases for homeopaths and similar symptom-chasers to practice on. My experience has convinced me that the remedy indicated on homeopathic indications, given in a material dose, is a powerful aid in making permanent cures.

I must say a few words on the question of dose. Many of us believe that if we only select the right remedy, the potency makes no difference. Repeated observations and experiments have shown me that I could obtain results from a material dose of a tincture which were impossible with the same tincture given on pills or a potency. I believe in selecting the remedy as closely as possible, according to the symptoms. Then give a dose large enough to have some effect. If you aggravate, well and good; you can easily give the medicine higher. If there is no result, most doctors will make the mistake of changing to some other medicine, and miss the cure they might have made by giving enough medicine to do the work. In further justification of large doses, I might add that all of the cases related were seen in consultation with homeopathic physicians; they were all obstinate cases that had resisted many kinds of treatment and, not infrequently, the same medicine that made the cure had already been given in potency without result.

Let me add a few words on the recognition of the conditions with which nervous dyspepsia is apt to be confused. First, you must exclude the other painful disorders of the abdomen, as gall-stone, appendicitis, movable kidney, renal colic, gastric ulcer and cancer. Next, you must exclude pyloric stenosis with its persistent vomiting, and all those diseases of distant organs which are apt to cause loss of appetite, nausea, vomiting, regurgitation of food, distress after eating and flatulence. These diseases are Bright's disease, with its uræmic dyspepsia; diabetes, with its catarrhal gastritis; the failing compensation of a dilated heart with its venous congestion of the gastric mucous membrane; cirrhosis of the liver; the anæmias; leukæmia; tubercular phthisis, with its initial catarrhal gastritis; the catarrhal gastritis, due to eating irritating food, or, as in elderly people, from insufficient mastication; and lastly, eye-strain and diseases of the generative organs.

With one exception, all of these conditions can be recognized by careful physical examination of the patient. The exception is the most important of them all—cancer of the stomach or of the surrounding viscera. In the first six months or so of its course, cancer of the stomach or upper abdomen may resemble nervous dyspepsia so closely as to deceive the very elect. If the cancer is at the pylorus, with the resulting obstruction, there will be the gastric

catarrh, the vomiting, the disappearance of free hydrochloric acid, the lactic acid fermentation and the persistent presence of blood in the stools on which an early diagnosis of cancer may be fairly made; but if the cancer is confined to the body of the stomach, or to the liver, or the pancreas, there will be no obstruction to the emptying of the stomach, no lactic acid fermentation, no decrease of hydrochloric acid, perhaps no vomiting. In such a case, in an elderly person, it may be impossible to differentiate nervous dyspepsia from cancer before the appearance of tumor. In fact, the appearance of tumor is the only positive sign of cancer in any part of the body, and this is especially true of the stomach. Intense pain, rapid emaciation and cachexia all point to cancer; but it must not be forgotten that nervous dyspepsia can cause as agonizing pain and just as marked emaciation as many cancers, and a very good imitation of a cancer cachexia. It must be remembered, also, that some cancers, during most of their course, have no pain, no vomiting and no cachexia. A practical rule is that in any patient over forty years of age, a persistent dyspepsia which is not relieved by rest in bed, simple diet and the indicated remedy, is open to the suspicion of being a cancer. A complicating element appears here in that some cases of cancer improve for a time under the same treatment. The best solution of the question is an exploratory operation and the early excision of a possible cancer. Other than this, you can simply wait for the development of tumor or the relentless progress of the disease to establish the diagnosis.

Summing up my observations on nervous dyspepsia, I note the following features:

First, of its nature:

1. Its frequent appearance after worry, trouble or some form of psychic shock.

2. Its frequent association with dilatation of the stomach or prolapsus of the stomach and abdominal viscera.

3. Its association with rheumatism. It is common to see an alternation between joint or muscle pains and the dyspeptic symptoms.

Secondly, its diagnosis:

1. The necessity of examining every organ of the body to search for a primary disease of which the dyspepsia may be merely a symptom.

2. With patients over forty-five years of age, the care necessary to distinguish nervous dyspepsia from cancer.

Thirdly, its treatment:

1. The need of generous, mixed diet and the folly of forbidding carbo-hydrates or other forms of food with the expectation of controlling the formation of gas.

2. The need of rest lying down in preference to open-air exercise. Open air is valuable, but it is a great mistake to order a weak, thin, tired patient to walk out doors until she has been well fed and rested.

3. The importance of correcting mechanical displacement or excessive acidity.

4. Having provided for rest, food and correction of mechanical displacement, the value of the homeopathic remedy in making a permanent cure is very great.

DISCUSSION.

NEWTON M. COLLINS: I was very sorry not to hear all of Dr. Laidlaw's paper. I simply heard him mention support of the stomach. I do not know what he advised in that, but I would like to recommend the adhesive plaster bandage as a support for a prolapsed stomach, or a pendulous abdomen or movable kidney, or even after a laporotomy, instead of a regular abdominal bandage. For the last two or three years I have been using the Z-O plaster, cutting it out to fit around the pelvis, and running down on women as far as practical without coming in contact with the hair, and then drawing it up taut on each side and having it extend around within about four or five inches of the spine. In that way you support the stomach, support the whole abdominal walls and relieve very, very many symptoms of tenderness and dragging, and symptoms that bryonia will clear up, but which the bandage will clear up in half the time. I would very strongly recommend it to your consideration, if Dr. Laidlaw did not do so.

S. T. BIRDSALL: The paper of Dr. Laidlaw's is a very interesting one. I presume we all agree with his conclusions. For the last four or five years I have been treating those cases by an entirely new method. I think that these cases of nervous dyspepsia almost invariably have their origin in some difficulty with the nerves that supply the stomach, and in almost every one of those cases I have found extreme tenderness over three or four nerves at the upper dorsal region; and I believe I can clear these cases up in a great deal less time than I have ever been able to before, by the ordinary homeopathic treatment, by means of mechanical vibration. It is surprising, in a case of that kind, how few treatments will reduce this soreness. I believe with Dr. Laidlaw that the disease primarily is one of peri-neuritis, possibly of rheumatic origin, involving those nerves, and as soon as you can relieve that, which you can do very quickly by mechanical vibration, all these symptoms disappear. In order to convince myself that that was the chief and only element in the cure, I have abstained in many of these cases from giving any remedy whatever, in making the test, and I find I can clear them up and get rid of them in that way a great deal faster than in any other.

REPORT

OF THE

BUREAU OF PÆDIATRICS.

"Dietetic Methods in the Nutritional and Gastro-Intestinal Diseases of Infancy and Early Childhood." - - - J. T. SIMONSON.
"Infantile Malnutrition," - - - - - - - - C. E. CHASE.

DIETETIC METHODS IN THE NUTRITIONAL AND GASTRO-INTESTINAL DISEASES OF INFANCY AND EARLY CHILDHOOD.

J. T. SIMONSON, M. D.,
NEW YORK CITY.

The great frequency of infantile malnutrition, gastro-intestinal diseases and rickety conditions in all classes of society, and the importance of proper feeding in their treatment, make the subject one of peculiar interest, not only to the Pædiatrist, but to the general practitioner, as a more general early recognition and correction of the faulty methods used would greatly lower the death rate resulting either directly or indirectly from such feeding.

Many writers consider proper feeding all that is necessary in the treatment of most cases of malnutrition, scurvy and ricketts.

The tendency of the majority of homeopathic physicians is to go to the other extreme and trust almost entirely to their remedies—considering the proper prescription all that is necessary to effect a cure, providing the food is not grossly improper.

The best results cannot be obtained by adhering to either method of treatment. Trusting entirely to proper feeding, falls far short of what can be accomplished by combining it with proper remedies, and *vice versa*.

Changes in the food elements, *i. e.*, increasing and decreasing fat, proteid and carbo-hydrate percentages to adapt the food to the child's powers of digestion are, if intelligently carried out, of the utmost importance, but the most carefully adjusted diet will frequently fall lamentably if loss of motor activity of the stomach and bowels, with all the pathological changes incident to an acute or chronic catarrhal condition, makes the proper digestion of any food impossible.

Conversely, the most accurate prescription is partially or completely nullified if the food is of such a nature and composition as to render complete and easy digestion impossible; filling the stomach and bowels with a mass of decomposing and fermenting material which causes or prolongs vomiting and diarrhœa, producing a mass of fermentation products and providing a culture ground for hosts of micro-organisms, rendering the normal bacteria of the gastro-intestinal tract pathogenic in character, adding to the catarrhal process by local irritation, taxing the elimination channels of the body far beyond their powers, producing a general toxæmia which completes the vicious circle, and by lowering the child's vitality, still further reducing the already weakened digestive powers.

The problem is to determine the character of food demanded by each individual case and adapt it as closely as possible to its individual needs and power of digestion, gradually increasing the strength of the food as improvement progresses.

A careful investigation of the method of feeding, from birth to the time of beginning illness, and of the digestive and intestinal functions at the time of beginning treatment is indispensable.

How was the child fed immediately after birth? If breast-fed, why was the change made to artificial food? The character of the artificial food which the child was taking when it first showed symptoms of illness is of the utmost importance, and an approximate idea of its composition will often reveal one of the most important of the causes of the child's illness.

Prolonged feeding with improper food is the probable cause of the very great majority of cases of malnutrition in its various phases, nutrition diseases, such as rickets and scurvy and the acute and chronic diseases of the gastro-intestinal tract.

Bad hygienic surroundings and inherited physical vices, of course, play a strong part in the causation of many cases of the diseases under discussion, but in most of them, also, a diet properly adapted to the child's condition is of the greatest assistance in treatment.

The disorders of nutrition include, among others, simple malnutrition, marasmus or infantile atrophy, acute inanition, scurvy and rickets.

The first three are simply states of the organism produced by a relative starvation due to faulty methods of feeding and inability to digest and assimilate food taken, or a condition in which destructive metabolism exceeds the constructive.

The last two are *diseases* of *perverted* nutrition. *All* are largely food diseases and their dietetic treatment depends upon proper adaptation of the food to the individual needs of the case, with a number of general principles applying to them all as a class. Many of them have been fed on one or all of the proprietary infant foods —often with very insufficient milk, and that usually boiled; condensed milk too greatly diluted with water and plain milk simply diluted and boiled, giving too high proteids and low fats. These errors in feeding produce a proteid indigestion—curdy sour stools,

fermentation, distended abdomen, colic, alternating constipation and diarrhœa, all accompanying the usual symptoms of malnutrition.

The usual result is a chronic gastro-intestinal dyspepsia with more or less catarrh, wasting, anæmia, nervous manifestations, etc., many of the symptoms being due to auto-intoxication.

In the acute and chronic gastro-intestinal dyspepsias of infancy and early childhood, we have practically the same class of feeding problem to meet, so they may be considered together.

Milk in some form is the food on which we must depend for the nutrition of the great majority of infants, and as it contains only four groups of food elements, and one of them, the ash, may be disregarded entirely, and another, the sugar, is easily adjusted, we have practically only two left for serious consideration—the fats and proteids; and a proper adjustment of their amounts in the food is the main desideratum in a great majority of the cases.

In all cases of wasting accompanied by a chronic gastro-intestinal dyspepsia, and either a diarrhœa or constipation, or the two conditions in alternation, the first thing is to gather all possible evidence from the stools, as to the character of the indigestion.

Where the main difficulty is with the proteids, we have an increase in gas accumulation, green, acid, watery, curded stools, usually excoriating, and considerable colic, or, gas and colic with large, hard, dry stools and more or less mucus. There may also be some curded vomiting. Where the fat is in excess, there is frequent regurgitation of small (or large) amounts of smooth, rancid milk, and frequent loose, soft, pasty stools usually yellow or pale olive green on the surface and yellowish beneath, also more or less mucus.

If there is marked fat indigestion—Westcott's High Fat Catarrh—we have considerable mucus, intimately mixed with the stool and the lumps of undigested fat. The stool often has a rancid, disgusting odor.

Where the fat and proteid are simply too low in quantity, the symptoms are those of wasting, exhaustion, usually constipation and extremely weak digestive powers, shown when any attempt is made to increase the strength of the food.

A little study of the symptoms will usually show which of the food elements is at fault, and we must begin our feeding accordingly.

In the home modification of milk for the sick infant there are several methods available for obtaining approximately any desired proportions of fats and proteids.

First. The twenty-ounce Top Milk Method, which is easy and very practical and satisfactory for normal feeding and ordinary cases of indigestion.

Second. What I shall call, for convenience sake, the Layer Method. Removing the milk in layers of 2, 4, 6, 8, 10, 12, etc., ounces from the top of a bottle in which the cream has risen, and diluting the amount so obtained with any desired amount of water. As these layers of milk contain a decreasing proportion of fat, and practically the same amount of proteid, we can thus obtain a milk

having any proportion of fats to proteids, which can be diluted with sugar water to any desired strength, from skimmed, or fat free milk, up to milk containing six or seven times as much fat is proteid.

Where the difficulty is with the proteid (Caseinogen) it can be met by using mixtures of whey and cream, by peptonizing the food after preparation in the proper strength, and by the addition of gruels to aid the digestion of the proteid.

Of the various methods for feeding cases of proteid indigestion, the whey and cream mixture has proven the most valuable in my hands.

Peptonized food I do not care to use for any length of time. The use of gruels is of doubtful value before three months of age, and after that will aid in only the mildest cases of proteid indigestion.

In the average case of malnutrition or marasmus with difficult casein digestion, I think the use of whey and cream is the most valuable plan. I usually begin with pure whey, or whey mixed with a thin dextrinized gruel, and gradually add top or plain milk as the child's digestion improves.

The food must be started at a point so low that the child has no difficulty in digesting it—increasing the strength as the condition improves. Before adding milk to the whey, the temperature of the latter will have to be raised to 160° to prevent further coagulation.

In some cases it is necessary to continue the whey mixtures for several weeks before changing to the ordinary methods of feeding, but the best results will be attained by increasing the strength of the food as rapidly as the child's digestion will permit.

In many cases of malnutrition, with chronic dyspepsia or chronic gastro-intestinal catarrh, the main difficulty is with the fats. This is most easily met by diluting plain milk, or even, in very obstinate cases, using partially or completely skimmed milk, increasing the fat by using milk from higher up in the bottle as the condition improves.

The advisability of using other foods than milk for the sick infant under one year of age is often very difficult to determine, and I believe the tendency is to decide that the patient cannot digest milk, and advise the use of some form of cereal, broth, or proprietary food, without sufficiently careful trial of milk properly prepared.

Treatment along this line is almost certain to end disastrously, after a shorter or longer period of time, in a large percentage of the cases in which it is adopted, as the number of infants who cannot digest *some* of the elements of milk is very small. However, *there are* occasional instances in which the child does not seem to respond to careful and repeated efforts to adapt its food, and in these it may be advisable to make a radical change for a short time, rather than continue with fractional changes in fat and proteid percentages. Here, we can take the milk away entirely and replace it by a food consisting entirely of carbo-hydrates (as a gruel), or by using some form of beef juice, meat broth, egg albumen or plasmon,

to give the child some proteid elements in its food. Standardized gruels (Chapin).

But such feeding should be discontinued as soon as possible, and a gradual return be made to milk, as the indefinite continuance of food containing no milk is sure to seriously interfere with the child's nutrition, and usually results in some form of malnutrition, scurvy or rickets.

The breast-fed infant presents a somewhat different proposition, when suffering from some acute or chronic gastro-intestinal disease. Here, in chronic cases, if the fault lies in the milk, as shown by analysis, an attempt must be made to improve it by proper methods of diet and exercise for the mother; but unfortunately the departure from the normal most apt to result seriously to the infant is the one most difficult to correct; that is, excessive proteids.

Where breast milk is too rich in fats or proteids, it is often possible to dilute it by giving the infant, just before placing it at the breast, from a few drams to an ounce of warm water; then after three to five minutes, the nursing may be interrupted and the same amount of water given again before allowing the child to finish nursing In this way the stomach is used as a vessel for mixing the milk and water.

In severe cases of acute inanition in young infants, a wet-nurse is almost indispensable, but even then the child's digestion may be so weak that the milk will have to be drawn with a breast pump, and after dilution, be fed to the infant with a medicine dropper. (Breck's feeder.)

Severe cases of malnutrition, diarrhœl disease, and premature infants often refuse to take sufficient nourishment to sustain life.

Here, gavage or forced feeding with the stomach tube is of considerable value, often the means of saving life. The manœuvre should be carried out rapidly, the jaws held apart to prevent gagging, and the intervals of feeding lengthened. It is free of danger and easily carried out.

In cases where there is difficulty in digesting normal breast milk, the addition of a few drops of "Lactopepton" or "Essence of Pepsin" give good results.

In the malnutrition and chronic gastric and intestinal dyspepsias of older children, the diet is also of much importance, and the indications for feeding are practically the same as in the infant.

The dietetic cause of the condition must be removed. This frequently means the discontinuance of a large variety of solid food, especially an excessive amount of starch, and returning the child to a diet of modified milk, scraped beef, egg-albumen, and, if no diarrhœa exists, fruit juices and cooked fruit in small quantities.

The milk should be fed in larger quantities than those given to a younger, healthy child taking the same formula.

As the condition improves, the diet can be gradually increased to that suitable for the child's age.

In the treatment of acute diarrhœal disease it is a great mistake to cut off milk entirely, in the milder cases, where dilution and peptonization may be sufficient. Again, the tendency is to keep the child too long on a food containing no milk, seriously interfering with gain in strength.

Excluding milk at the beginning of acute diarrhœa is perfectly proper, but its continuance, longer than absolutely necessary, is a mistake.

In chronic diarrhœal disease, the total exclusion of milk for each acute aggravation is also unnecessary, unless under the conditions previously mentioned.

The dietetic treatment of constipation is often a matter of some difficulty, but I most thoroughly disagree with the statement frequently made that a bottle-fed infant is usually constipated, has stools small, dry and more or less formed. This opinion is, I believe, always based on observation of infants fed on laboratory milk, and does not apply when the food is an intelligent home modification.

The usual mistake made is to attempt to overcome constipation by increasing the percentage of fats beyond the amount normally required for an infant of a given age. This usually results in gastric derangement, next, a failure of appetite, and finally, if persisted in, a high fat catarrh of the intestine with the indigestion of all the elements of milk, and a consequent malnutrition.

The correct dietetic method is to increase all the elements of milk, decrease excessive proteids or add a dextrinized gruel.

An increase in fats will often result in an increased constipation. I have often had good results, notwithstanding the popular idea of the difficulty of digestion of veal, from one feeding per day of veal broth, made with all soup greens, except the onion, before allowing to cool for removal of the fat.

The proper methods of feeding cases of "rickets"—as the reduction of all carbo-hydrates to a minimum, or their entire exclusion, and an increase in fats and proteids—both in milk and as beef and cod liver oil are simple and well understood. All sterilization must be stopped.

In "scurvy" the essential dietetic charge is the removal of all *dead food* from the diet, giving fresh milk, beef juice, and fruit juice only.

The great difficulty in the way of proper infant feeding, by the profession at large, has been the imagined difficulty of home modification and the consequent recourse to proprietary foods.

A little study of a few general principles and their daily application in practice will give results which will cause a rapid disappearance of a great part of the supposed percentage bug-a-boo.

INFANTILE MALNUTRITION.

C. E. CHASE,
UTICA, N. Y.

Infantile malnutrition, lying at the parting of the ways, leading towards severe forms of marasmus on the one hand, and towards rachitis, scurvy and the various diathetic and constitutional diseases on the other, is one of the most frequent, oft-times obstinate and troublesome, and at the same time one of the most satisfactory diseases of infancy which the physician is called upon to treat; for what can be more satisfactory than to see some poor, miserable, scrawny, skeleton-like creature, in the last stages of mal-assimilation, weighing often much less than at birth, under the influence of proper hygienic and dietetic methods, gradually lose the wail of hunger and the cry of colic, and assume an aspect of peaceful contentment, under your ministrations; the wrinkles in the face and the flabby folds of skin fill up and become smoothed out; the dry and yellowish-tinted skin assumes the fairness and fresh color of health; the weight increases, and a healthy, normal infant in a few weeks takes the place of the weazened, repulsive-looking specimen of a few short weeks before.

Some of these cases undoubtedly owe their condition to hereditary influences, such as tubercular and syphilitic parentage, and a few of them, in spite of all treatment, will descend to the severest forms of marasmus and inanition, developing perhaps meningitis, or mesenteric tuberculosis, or the extremes of syphilitic poisoning, and finally succumb to the inevitable.

The large majority, however, are amenable to treatment, and even the children of tubercular parentage, if carefully treated from birth, and subjected to proper dietary and hygienic surroundings throughout childhood and youth, may be saved from the clutches of the Great White Scourge.

It is surprising what an amount of ignorance exists among those who are most intimately brought into contact with the new-born babe, in regard to the proper care and feeding of the little child. Not only mothers, who by reason often of inexperience, oftener of wilful ignorance, lack of education, or a desire to be relieved of the exacting cares of maternity, but nurses themselves, who of all people should be in possession of proper information on the subject of infant-feeding, are ignorant of its first principles, and the foundations of malnutrition and various digestive diseases are laid in the first few days or weeks of the infant's life. The history of many a case gives a story of indigestion and colic dating from the first day's feeding with crackers and sweetened water; then the story of frequent nursing whenever the baby cried, by which the indigestion

was still further increased; finally a resorting to various improper milk combinations, patent foods, etc., until the child was reduced to the last extremities of emaciation and inanition.

Such a case occurred to me very recently in a neighboring village, the condition being complicated, however, by the illness of the father of the child, causing much anxiety on the part of the mother. The baby's food had been juggled with too much, though it had been under the care of a young physician near by, who, however, had had little or no experience with infants.

When I saw the child it was extremely emaciated, vomited everything, had a green, watery, offensive diarrhœa, abdomen tympanitic, extremities cold, intense thirst and restlessness, and had been given up by the physician and friends, and was altogether a most unpromising case.

It had been taking modified milk, which was stopped at once and albumen water given, followed in a day or two by mutton broth; high saline enemas given twice a day, body rubbed with oil and remedies exhibited as indicated.

For two or three weeks it seemed a hopeless fight; the abdomen was for a time enormously distended like a balloon, and it looked as if it would burst, causing a semi-comatose condition, probably from pressure against the diaphragm; a flannel bandage was applied to it, and as the child gained strength the distention gradually subsided; the recovery was very gradual, but after two or three weeks its strength had much increased, after which time it rapidly gained in weight and became as plump as any baby of its age.

Another case, which was a valuable object lesson to me as to the need of perseverance in spite of apparently hopeless conditions, occurred in the early days of my practice, in the summer of 1885. A lady gave birth to twins, a boy and a girl, and being unable to nurse them, a combination of the circumstances mentioned above brought them, at the age of three months, when they came under my observation, to the very gates of death; both were emaciated to the last degree, convulsed with colic, sleepless, crying constantly, so weak that it was a question which would die first; the boy, in fact, did die about a week after he came to Utica; the girl, however, with the tenacity of life inherent in our fair sisters, refused to succumb, and after a hard and discouraging fight, finally recovered, and is now teaching school in Porto Rico, earning money to finish her college course. The dietetic measure which, as I remember, turned the scale in her favor in that case was Murdock's food, a preparation much used in those days, which has been replaced in recent years by Bovinine.

Malnutrition is a large factor in the production of such diathetic diseases as rachitis, tuberculosis, etc.—larger even in the opinion of modern investigators than heredity, as tuberculosis is now considered to be, undoubtedly, a preventable disease.

Malnutrition in infancy lays the foundation for these diseases by

inducing dyspeptic conditions in youth, and so weakening the constitution as to render it liable to the inroads of disease under the strain and stress of modern life.

Many cases of rachitis and scurvy are found among the young of our foreign population, as a tour through the Italian quarter of any of our larger cities will amply demonstrate.

The treatment of cases of malnutrition is, of course, mainly dietetic, although the homeopathic remedy has always, in my cases, played an important part, and I have no sympathy with the statements made by Holt, for instance, in his "Diseases of Children," when he says, with the therapeutic pessimism always manifested by our old-school friends, that "drugs are of no value whatever in the treatment of these conditions."

I have found great assistance in the use of such remedies as Calc. C. Ars. ars. Iod. Cup. ars. Carbo. veg. China, Cina, Lyc. Op. Nux, Suph. Verat, etc. Calc. C. is frequently indicated, and has done me yoeman's service, as the sweating head, protuberant abdomen, cold feet, and acid tendency are very frequent combinations. Cup. Ars. controls the colic and green stools as nothing else will. The thirst and restlessness of Ars., the cold sweat and collapse of Carbo. veg., the flatulency of China and Lyc., the irritability and nervousness of Cina, are all extremely helpful.

A dietetic treatment must be prescribed for a child as carefully as the remedies are selected; the age of the child has little to do with the case, the digestive ability being the only safe criterion, as I have often given a five or six months old baby a food strength fitted to a healthy child of one or two weeks.

A very large proportion of children are absolutely unable for a time to take milk in any form. I think this is due many times to the fact that the milk comes from cows fed on ensilage, and even brewer's grains, which make the milk easily fermentable and induce acidity and flatulency. Be this as it may, I find the stools frequently loaded with curds, and the only way to prevent their formation is to discontinue the milk until the intestinal canal is entirely free from them. As a substitute I use albumen water for a day or so, and follow with mutton broth, sometimes mixed with egg albumen, or without, making the mutton broth in proportion of one-half pound to a pint for young infants, or one pound to the pint for older ones.

After the age of four or five months, I use in addition to the broth, barley, or barley water.

When the case has so far recovered as to permit a return to milk, I begin with a whey and cream mixture; say, to begin with, one teaspoonful of cream to three or four ounces of whey; or whey and plain water; or whey and barley water, according to the age or digestive capacity of the child. Sometimes I add a little cream to the mutton broth and gradually return to milk along that channel.

I am much in favor of modified milk as against patent foods, as I think, with care and patience, milk can be adapted to nearly all children; however, there are some cases that refuse absolutely to digest milk, and other foods have to be used.

Malted milk sometimes serves an excellent purpose temporarily, but must not be continued too long, or scurvy may develop, as occurred to a case of mine last year. Of the patent infant foods I have had very satisfactory results from Horlick's infant food.

Some years ago a very severe case of malnutrition resisted every effort to bring about a favorable turn. The boy was very much emaciated, and for three months I tried every conceivable combination without result, the child never gaining a pound.

The parents were perfectly healthy, and I could see no reason for the condition. I finally received a sample of Just's food and gave him that as a last resort. It was just what he wanted; he began to improve immediately, and in a month was as stout as any child of his age. He was very slow in walking, however, having developed some spinal weakness; he is now seven or eight years old, and has nearly acquired a normal gait.

Occasionally, condensed milk is the only thing which will agree with a certain child, but I do not like it as it is deficient in fat and proteid, and contains too much sugar. Children using it exclusively, while they become fat, do not seem to acquire the muscular and bone strength which they need.

At the House of the Good Shepard, in Utica, which is a home for children of often uncertain parentage, with which I have been connected for a good many years, they have had excellent results from the use of cream and whey mixtures in feeble children. The nurse in charge is a graduate of St. Margaret's Home, Albany, has had large experience in the care of sick children, and has been of great assistance to me in these cases, of which there has, naturally, been a large number and in great variety.

Another measure which I consider indispensable in these cases, and which has been productive of most beneficial results, consists in the use of high saline enemas with the long rectal tube; I have these enemas given twice daily in the average case; by their use the intense thirst is markedly relieved, the colon and rectum are freed from accumulated curds and other distress, the intestines are freed from gas, the distension relieved, and the infant relieved for a time of the constant exhausting straining and frequent stools, and the fluid waste in a measure released by absorption of the saline fluid.

REPORT

OF THE

BUREAU OF MATERIA MEDICA.

"Precision in Homœopathic Prescribing," - - - STUART CLOSE.
"A Few Cases Illustrating the Superiority of Homœopathic Therapeutics," - - - - - - D. E. S. COLEMAN.
"Observations on the Homœopathic Therapeutics of Tuberculosis," - - - - - - - - GUY B. STEARNS.
"A Consideration which the Relationship of our Materia Medica bears to the Treatment of Disease," - - RUDOLPH F. RABE

PRECISION IN HOMŒOPATHIC PRESCRIBING.

STUART CLOSE, M. D.,
BROOKLYN, N. Y.

Precision in prescribing is the ideal of every conscientious homeopathician. Though he may often feel, in view of his shortcomings, that, like faith, it is "the substance of things hoped for," he does not cease in his efforts to attain it, for he realizes that upon this, more than anything else, depends his success as a physician. Just in proportion to his ability to attain precision in prescribing will be his power to cure his cases. A pleasing personality, good manners, an engaging address, evidences of taste in personal environment, tact and sympathy, are all requisite and desirable, but without that precision of method in prescribing, which alone brings health to the sick, they will be counted small in the final weighing.

The highest and only object of homeopathic prescribing is to *make sick people well.* It is not to relieve pain, reduce temperature, strengthen the heart action, stimulate the nervous system, or do any other of the particular things which pass current as the proper "indications" for so-called "rational treatment," but by means of the homeopathic remedy to bring about a true curative reaction. Pain, fever, inflammation, weak heart action, and all the other pathological generalities are not evils *per se,* although to traditional medicine they are bug-bears of fiercest mien; neither are they the basis of a curative prescription. To the enlightened mind they are simply the cries of the suffering organism for help. Of themselves,

smothered, indefinite, almost inarticulate, the cries afford no more indication as to *how help is to be afforded* than does the cry of the drowning man teach the life guard how to swim or how to manage a frantic, struggling victim of the treacherous undertow, after he has reached him. The cries simply announce that a life is in danger, and indicate the direction in which the guard must proceed. The mere existence of pain or fever does not determine the homeopathic prescription. That is determined by the symptoms of the patient, which are the articulate and perfectly intelligible language of disease when that language has been learned.

The homeopathic physician knows the language of disease. He knows, too, the language of materia medica—of drugs—for drugs also have a language or medium of communication with the human organism, and these two languages are similar. Medicine and disease are relatives, first, second or tenth cousins perhaps, but relatives nevertheless, who speak the same or very similar tongue. The physician is like the genealogist, who, having looked up the respective pedigrees, introduces the long-parted kinsman to each other, and so helps to bring the family together in cordial relation. If, by reason of long separation, they have acquired different idioms or dialects, he interprets them to each other.

If the physician knows only a few words of the language of drugs, as, that digitalis stimulates the heart, or that morphine deadens pain, for example, he will make but a poor interpreter; as likely to provoke quarrels, misunderstandings and ruptures as he is to promote concord and union. The result will be the same if he knows only the gross pathological and diagnostic generalizations of disease.

Precision in prescribing cannot be thus attained.

This was illustrated to me in a startling manner quite recently. The case was one of profound prostration, with decided melancholia and delusions, in a woman about fifty years of age. There was a history of domestic unhappiness and anxiety for many years. Vital energy was at lowest ebb, every function depressed. The heart was very weak, circulation poor, and respiration shallow. There was aversion to all food, delusions of poison, leading to refusal of food, sleeplessness, obstinate atonic constipation, and great general weakness.

Physical examination revealed no serious organic lesions, but did reveal chronic traumatic endometritis and metritis, dependent upon an immense bilateral laceration involving almost the entire cervix uteri, a complete laceration of the perineum with rectocele and cystocele, the pelvic floor consisting of but little more than membraneous attachments. This pelvic condition had existed for over twenty years, since the birth of her second child, and no attempt had ever been made to repair the ghastly laceration.

The patient was put to bed, carefully prescribed for, fed as much as she could be persuaded, without force, to take, and nursed a few weeks until she had gained enough strength to make it safe to

attempt an operation. The operation, which included amputation of the cervix, curetting, repair of bladder, rectum and perineum, was successfully performed and a perfect result obtained. Surgically, the patient made a rapid and uneventful recovery, leaving the hospital in the fourth week. Medically, she made but slow progress for several weeks, as was expected, but there was decided gain. Her melancholia and delusions persisted, though gradually diminishing, so that she was no longer suspicious of poison, and did not refuse small quantities of food. In the course of four weeks after leaving the hospital, she had gained so much strength that she was able to walk about the house, and was making fair progress. Now came officious friends and relatives with their inevitable criticisms and advice to change treatment, and presently was recalled the former allopathic physician under whose neglect she had reached the lowest round of the ladder of life. He professed himself shocked at her condition, denounced the operation as unnecessary and unwise "in her weak condition," declared that she was being systematically starved to death, and that her *heart* was the organic seat of all her troubles. He ordered a powerful heart stimulant, with enforced super feeding, and daily cathartics" to keep the bowels open." After less than a week of this line of treatment the patient died of paralysis of the heart, due entirely to over-stimulation. The equilibrium of the organic forces was destroyed and the small fund of strength which I had created and was so carefully husbanding, was rapidly exhausted.

Such a case illustrates the difference between a fluent command of the language of symptomatology and that smattering of a few "guide-book phrases" which commonly pass current as a working vocabulary.

Precision in prescribing means the ability to take all the elements of a case into consideration; to give to each factor its due position and relative importance; to determine what, in each case, is curable; to decide what is medical and what is mechanical or surgical; to remove obstacles to the cure; to see what is the healing property in all medicines and in each medicine in particular; to know how to adapt that which is healing in the medicine to that which is morbid in the patient, so as to bring about convalescence, and to do all this intelligently, according to plain, reasonable and definite principles. (Organon, section 3.)

In Homeopathy alone do we find the means of fulfilling these broad requirements, and to Hahnemann alone is due the honor of having pointed out the way and formulated the method. In his "Organon of the Healing Art," Hahnemann has set forth the law of cure and the manner of its discovery; the philosophical principles deduced from it; the nature of disease; the means of cure and mode of developing its agents, including the law of potentiation; the nature and function of symptoms; the method of eliciting symptoms in the examination of patients and provers; the mode of selecting the remedy; the management of the case in the determination of

dose and repetition of doses; the sequence of remedies; the homeopathic prognosis and the place and scope of auxiliary treatment. Under these heads are comprised the more general requirements of homeopathic education which must be fulfilled by one who aspires to precision in homeopathic prescribing.

One can hardly fail to be impressed with the immense advantage accruing to the physician who possesses such a simple, practical logical method. It is broad enough to meet all requirements and adaptable to every contingency. On the importance of method in general there is little need to dwell. We all feel it. That we should "act on principle, and not float through the world like straws upon a river," as Susanna Wesley wrote to her son John, is something that appeals to every one of us. "We are all creatures of habit," she wrote; "we must cultivate good habits, for they soon master us, and we must be controlled by that which is good. Life is very precious; we must give it back to God some day, so let us get the most from it. Let us methodize the hours so we may best improve them."

So the great exemplars of Homeopathy have said to themselves, and saying, have proceeded to exemplify it in their daily work. Hahnemann outlined the method in his "Organon," and furnished the material in his "Materia Medica Pura and Chronic Diseases." Bonninghausen, with his great analytical mind, took up the work and in his "Therapeutic Pocket Book" gave us a masterpiece of analysis, classification and generalization such as the medical world had never seen before—an absolutely unique work that has never been, and never will be superseded. The method of Hahnmann and Bonninghausen is the method of to-day, and the man who has not mastered it is "out of the running," so far as expert Homeopathy is concerned. He has not learned the grammar of his language.

This leads to the further remark that the direct and constant use of books of reference as instruments of precision is peculiar to, and characteristic of, the expert homeopathic prescriber. The materia medica manual and the repertory are his inseparable companions. With these is associated the systematic use of the carefully-kept case record of symptoms, without which accurate work is impossible.

In its provings of drugs upon healthy, intelligent human beings, who are able to express and record subjective and objective conditions as modified in function and sensation, Homeopathy has an incomparable instrument of precision quite peculiar to itself. The living human organism, body and mind, is the most sensitive, most delicate and most powerful re-agent known to science.

For practical therapeutic purposes the most modern chemical, physiological and biological laboratories, with all their elaborate equipment, are not to be compared with it in scope and usefulness, nor can they take its place. With profound philosophical insight, Bonninghausen wrote: "The indisputably purely dynamic property of medical substances, more sublimated and spirit-like than that of the imponderables, by virtue of which they are able to cause or

remove disturbances in the living organism, lies just as far outside of the limits of chemistry as of botany, and forms a basis of science by itself, which rests purely and alone upon the provings and experience on the living body, never on the dead body. The laws of chemistry only enter on their dominion when life has departed and the body is given over to decomposition."

Consider for a moment what we have in the record of a well-conducted drug proving which makes for precision in prescribing. Remember that, to the homeopathic physician, the pathogenic action of a drug is the key to its therapeutic use; and that every least detail of its action, as observed in the proving, is important as furnishing one more indication for its selection in the cure of disease. Every variation in the manifestation of disease in the individual patient has its counterpart in similar characteristic variations in the pathogenetic action of drugs, even to the minutest detail.

Take up a proving now, and study it with relation to its action upon each particular organ and function; to distinctly regional parts of the body; to the sides of the body; to the modalities as affected by heat, cold, position, motion, moisture, dryness, light, noise, times of the day, etc. When to this we add a study of the states of the mind and emotions; of sleep and dreams; of desires and aversions, with their various modalities as revealed in the proving and verified at the bedside, we begin to see what is meant by precision in homeopathic prescribing. This mode of studying drugs and disease belongs exclusively to Homeopathy. It affords scope for the exercise of one's highest powers, and insures results incomparably better than any other method.

To the uninitiated the contemplation of the vast collection of symptoms in our materia medica, or even of some single drug, like sulphur or calcarea, is confusing and disheartening; and when to this he adds the equally vast symptomatology of disease, varying in every individual, he is ready to throw up his hands in despair. It looks to him like chaos. He can hardly be made to believe that there is a principle by which this vast array of details has all been reduced to order, and that it is perfectly comprehensible and within the grasp of every rightly instructed physician. The principle of similia and the science of classification simplifies and elucidates everything. Possessed of the materia medica and its various analytical and classified repertories and indexes, trained in their systematic use, and guided always by the law of similars, he occupies the point of strategic control. He can quickly find the counterpart of any and every group of symptoms which presents itself to him, and when he has found the similar remedy, in symptom and dose, he has found the true curative. Difficulties he will meet, of course, but they decrease and disappear as he becomes more and more expert. It is a triumph of method which would have delighted the heart of Susanna Wesley and her son John.

The ever-existent aspiration and progress towards precision in prescribing has led, in the course of time, to the development of

homeopathic prescribing as a specialty. Specialization is the order of the day in all departments of activity. Medicine and surgery are in the van. Both are cut up into numerous specialties. Many homeopathic conservatives view this modern tendency with alarm. From their point of view it portends the ultimate extinction of Homeopathy. We sympathize with them, while pointing out their errors. They fail to realize the abiding character of truth and the inevitable influence of the law of progress. There is no escape from the law of evolution. It is useless to oppose or obstruct it. The part of wisdom is to accept it and align ourselves with the all-conquering power. Looking over the field, it is easy to perceive the operation of the law in matters homeopathic. Many have recognized the development of specialties in general medicine, but how few have perceived that, following the operation of this great law of nature, Homeopathy itself—the art and science of therapeutics—has become a specialty, and the greatest of all specialties. Slowly, quietly, so gradually as to be almost unperceived, the segregation has been going on until we may now find hundreds of men and women throughout the world who, by their singleness of purpose and concentration of energy, have set themselves apart from the ranks of general medicine and become specialists in homeopathic therapeutics.

They are experts in materia medica, masters of the art of homeopathic examination, diagnosis and prognosis, prescribers of precision. They are likewise the most efficient teachers and missionaries of the truth as it is in Hahnemann, because they proclaim and exemplify the law of cure and the power of drugs, both as pathogenetic and healing agents. They warn the profession and the public of the dangers of indiscriminate drugging with crude and massive doses, and they instruct the people in the better way of the single, simple, similar remedy in the minimum dose. They put their critics and opponents to confusion by curing acute and chronic diseases rapidly, safely and permanently, even in cases pronounced incurable or condemned to the knife. They devote themselves to the science of medication, and precision in homeopathic prescribing is their realized ideal. In nearly every city and in many towns they may be found, singly or in groups of from five to fifty, working quietly and harmoniously together for the good of homeopathy and humanity. They form little local societies or clubs, and meet together frequently for study and discussion. These groups are known to each other, and keep in touch largely through the medium of the International Hahnemannian Association, of which the majority of the individuals are members, and which is itself an association of specialists. They are very much in earnest, and they are sincere. While they are not announcing their presence in the world with the blare of trumpets, they are doing the real work of homeopathy, and duplicating the cures of the old masters, whose work it is fashionable to bewail as a thing of the past. As a matter of fact, there were never as many expert homeopathic prescribers in the world as there are

to-day, and there never were better, more perfect or more brilliant cures made than are being made to-day.

Let no man fear for the future of Homeopathy. In specialization, Homeopathy has come into her own and become independent. The Hahnemannian of to-day is a specialist, with a field limited, not by any particular organ or function of the human body, but only by the resources of the homeopathic materia medica, and his own capacity for applying it.

That this line of work appeals only to a certain type of mind, and draws its recruits from the whole body of the profession, is only in accord with the law of attraction by which the whole field of specialties is governed. "To every man his work," and "Blessed is that man who has found his work," as Fra Elbertus says.

In this wise specialization, developing naturally out of the exigencies of the situation, and in the existence within the school of an increasingly strong body of experts, whose energy, ability and enthusiasm are devoted to upholding and exemplifying its principles in their purity and entirety, Homeopathy has its strongest assurance of perpetuity.

Homeopathy as a school and an organization may have its factions, its dissensions, its strifes within and without, but Homeopathy itself, like the "Church Universal," has taken its place on a plane far above all turmoil and strife. The school may be threatened by organized foes and legislative disruption, but Homeopathy cannot thus be injured.

As well fear that the science of chemistry will be destroyed because the atomic theory or the law of chemical affinity is assailed, or because the pure food law has been enacted and is about to be enforced against those who have perverted that noble art to base and selfish ends, as that Homeopathy will be destroyed or jeopardized by any legislative enactment.

The school must and will protect itself from all such assaults, but in doing so it will not forget that, more important even than this, is the nurture and preservation of that pure spirit of Homeopathy which has inspired its greatest exemplars since the time of Hahnemann, and that we should strive always, in perfecting our methods and technique, to attain Precision in Prescribing.

A FEW CASES ILLUSTRATING THE SUPERIORITY OF HOMŒOPATHIC THERAPEUTICS.

D. E. S. COLEMAN, Ph. B., M. D.,
NEW YORK CITY.

As a believer in Homeopathy in its purest form, it is my desire to do anything in my power towards the promulgation of our natural law of cure. Many wonderful results which we are morally sure could not be effected by allopathic methods appear in our practices daily. The "old school" advocates may claim, however, that we do not know whether their measures will cure until they have been tried, notwithstanding that they brand most chronic, and many acute diseases, incurable. Mistaken diagnosis is still another cry—as if it were not possible for a good homeopath to also be a good diagnostician. It is my intention, therefore, to report cures or marked ameliorations that I have been able to bring about in cases where allopathy had been tried with absolute failure. The time allotted to the paper necessitates the restriction to a few such.

On May 2, 1904, I was called hurriedly to see a young lady thirty-four years of age. I found that she was in an epileptic convulsion. She suffered from several previous attacks, for which her physician had prescribed large doses of bromides. Her symptoms were those of *true* epilepsy. Premonitory itching of the skin several days before seizure. At the beginning her head turned to the left, but there was a sensation as if it were turning before it actually did so. Fell suddenly and passed through the clonic and tonic spasms, frothed at the mouth, bit tongue, face became purple, pupils dilated, and insensible. Langour and sleep followed. Menstruation too often, irregular and rather scanty. Attacks came between menstrual periods. After an examination I decided that the condition of her eyes (she suffered from hyperopic astigmatism) was an important *exciting* cause, and advised that she visit a well-known homeopathic oculist and have her glasses changed. I entered a strong protest against the use of bromides. Instead of calling upon the homeopathic oculist, she consulted one of the "old school." He agreed with my diagnosis, and prescribed a change of glasses. Not satisfied, she allowed herself to be enticed into treatment by a most eminent allopathic authority. He agreed with the diagnosis, but disagreed with the treatment. "Bromides are the only thing that will help you," he said. Her father told me of the decision. They were unfamiliar with Homeopathy at that time. I did all in my power to offset the beginning of this pernicious poisoning. On January 6, 1906, I was called to see her for what turned out to be a very serious case of double typhoid pneumonia. This was treated homeopathically from the beginning, and cannot be discussed in this paper, therefore.

She had been under the bromide treatment up to this time, and her skin was badly erupted. On March 3d, during convalescence, she was taken with a severe epileptic attack. On March 4th two attacks. On March 5th I prescribed belladonna 30th, four times daily. The symptoms were as follows: Premonitory itching of the skin. At first things seemed to be getting farther away, then head turned to the right or left, lost consciousness, drew up legs, hands opened and shut, kicked feet. Nausea and weakness after attack, dull pain as if bruised in neck, occiput and crown of head when lying down, did not hurt while sitting up, worse from touch. Attacks came on after using eyes. March 8th, great nervousness and palpitation of heart, feels as if she were going to have an attack. Eyes feel strained. Belladonna was discontinued and Natrum muriaticum 30th was given every four hours. March 11th two milder convulsions; Natrum muriaticum 30th every six hours. March 17th another attack. I reviewed the case carefully and found belladonna again indicated. At first I prescribed it every two hours. I told her to diminish the frequency of the dose as she grew better. The attacks grew less frequent and severe. When she was able, I had her eyes examined by the homeopathic oculist. He agreed with the diagnosis. On March 29th I made my last visit. She went to the country shortly after. The following is an extract from her letter dated February 5, 1907:

"I took your medicine for about three or four weeks after March 29th, at first three times daily, later once or twice a day, and some days not at all. Had two attacks during month of April, one of which was very severe, having been unconscious for nearly an hour; the other was not quite so bad. They were about two weeks apart. Had one about the first of May which was not very severe, and the last one was on May 14th, which was also not very bad. At times after that I would feel as though an attack were coming on, but it would wear off in a few minutes. That has now entirely disappeared, and I feel perfectly well and have done so for the last few months. About the first of May I began taking warm baths. I took absolutely no other medicines."

I wish to add that she gave up attending to business. Someone will claim that warm baths, relief from business cares and wearing of the proper glasses produced the cure. I claim, however, that the warm baths were only palliative. Remember that her attacks had grown very much less severe before she began to take them. Business and eye-strain were only exciting causes. Hahnemann said: "Remove the cause and treat the patient." Removing the cause alone, or giving the drug without removing the cause, would not be Homeopathy as Hahnemann wished it understood. No one would think of prescribing Apis for stinging pains while one were sitting under a beehive, or Nux vomica for another until his mother-in-law was removed from the house. I know I am not "out of the woods" yet with this case, but I have my compass, so well pointing that I am not losing sleep over the outcome.

Mrs. X. had been suffering from fissure in ano, presenting the following symptoms, off and on, for three or four years. Practically, not the slightest relief from allopathic treatment. Great throbbing, cutting pain in rectum extending to lower end of sacrum, then upwards and around the waist. This pain came on immediately after a movement of the bowels and continued many hours; she sometimes walked the floor all night. Blood was often passed with the stool. I prescribed Nitric acid 30th every two hours. After the second dose she was *entirely* well, and has never had another attack. This was three years ago. I told her to continue the remedy three times daily until the vial (two drachm) was empty. I did this to guard against relapse.

Valvular heart disease and chronic parenchymatous nephritis in a man about fifty years of age. Double murmur heard at apex, systolic murmur transmitted to the left; double murmur heard at second right intercostal space, systolic murmur transmitted to the neck. The murmurs were extremely pronounced. Urinary examination showed the presence of albumen, pus corpuscles, epithelia from the convoluted tubules containing fat, and granular casts. He was passing less than twenty ounces a day. Clinical symptoms: Stupid and drowsy, dyspnœa, excessive œdema, no thirst. Digitalis was given for twenty-four hours in the usual allopathic way, with the result that the patient grew much worse. Citrate of caffience was then substituted. On the following day the man was in marked stupor, showing every sign of fast approaching death. I suggested Apis 30th to the attending physician. He, not being a believer in the higher potencies, put eight drops of the tincture in a glass of water and gave a teaspoonful every hour. In the next twenty-four hours the man passed one hundred and ten ounces of urine, and showed very marked improvement. For about a week the average was one hundred ounces daily. By that time he was out of bed, the œdema had disappeared, and he presented no subjective symptoms. Unless you listened to his heart and examined his urine, you could not tell he were ill.

Male patient suffering from carbuncle, grew steadily worse under the carbolic acid and curette treatment. Symptoms: Burning pain relieved by heat. Improvement within a few hours from one dose of Arsenicum 200th, progressing steadily to a complete cure without repetition of the dose.

When and how often to repeat is a difficult question to decide, and must be individualized in every case. Some patients do better on repeated doses; others on single. Again, the nature of the trouble, the character and potency of the drug have to be taken into consideration. To my mind, the correct procedure is to find out, if possible, how long a remedy acts in a given case, whether it be five minutes or a year, and repeat accordingly. As a general rule, the more acute the symptoms, the more often should be the repetition.

Alveolar abscess after extraction of the second left molar tooth, some of the root being retained and the first molar injured. There was a discharge of thick, yellow, foul-smelling pus; sensitiveness to touch. "Regular" treatment for a number of days without the slightest result. Cured within twenty-four hours by Hepar sulphur 30th every two hours. The broken root came away piece-meal for some time after, but there was absolutely no return of the abscess.

A student of the New York Homeopathic College, who had formerly studied at the Cornell Medical College, came to me one morning suffering from sciatica. Pains worse from motion, better from heat. Bryonia 30th every hour was prescribed. The following appeared in his letter to me, which is more conclusive than anything I could write:

"I began to take the pills at once after you gave them to me, and before I left college that day began to feel less pain; slept well that night, and the next morning had no pain at all; simply a little soreness. Before the next noon had no feeling of the trouble. When I told the students about it they would not believe me until they saw me go upstairs to see if I were lame. This beats the record, for this trouble used to last me two weeks, and I took salol and phenacetine until my stomach went back on it, or until my ears roared so that I could not endure it any more. Want to know what you gave me, but half think it was Byronia; yet do not know. If such work as this continues you will make me such an enthusiast over Homeopathy that I will not be able to attend to business. I am getting more faith in it every day, and only wish I could learn the materia medica faster, but have very little time to study it. You see, there is so much else to study and business besides, that materia medica has but a small place left; *but I will get there in time.*"

You can bet he will *get there in time;*" and not such a very long time at that. This is the kind of men we want.

DISCUSSION.

JOHN L. MOFFAT: I have spoken more than once about what may be a fad of mine, one of the chief values of societies and the way in which we can make our clinical reports of most benefit, and that is, to consider ourselves our most severe critics, and not to have the wish father to the thought; to have every clinical case so reported that our critics, our enemies, the people who do not want to believe, will have to accept that evidence as to the diagnosis. Now, in this case reported, a dose of arsenic was given, the patient got better. Was that in just such a condition that the patient would have gotten better, anyway? I am not doubting the case. I know perfectly well the effect of the medicines, but I would like to have these cases so recorded that any scientific observer will say: "That is a clear case; that is made out all right; he has answered all ques-

tions in his case." What else could possibly have been the cause of the improvement? Was the improvement only temporary? How long had the patient been sick? How soon after the administration of the remedy was the relief found? How permanent was that relief? I think those are cardinal principles. And then, when we come together and, in a spirit of impersonal, scientific, friendly criticism, go for one another, dig our papers to pieces; then when they have stood the test, they are all the more firmly established in our literature, and will be of so much more value. We have been doing this for all the years, and we have convinced ourselves. Once in a great while we have convinced somebody else. I think we can convince them much more rapidly if we will have this system of scientific criticism that I first learned in the New York Homeopathic Materia Medica Society a great many years ago.

Now, that case of nitric acid; what was the pathology? whether a case of hemorrhoids or a case of fissure? Was there any examination made, or were we doing what we all are apt to do, saying, "Why, there is the symptom, here is the remedy that will help it; that is all that is necessary?" It is all that is necessary for me, all that is necessary for you, but it is not all that is necessary for Dr. Smith, maybe. It is just that question. We are already converted. Can we convert Dr. Smith, and can we make Dr. Smith say, "Yes, you are taking a thoroughly scientific basis." Be thorough, be your own most severe critic. As I said before at one of our State Society meetings, up at Lake George—I am perfectly well satisfied, so well satisfied, of the value of a remedy, that I may go on giving it and pin my faith on that remedy; but it is very seldom that I will get up, in an individual case, and say that that result was the effect of that remedy, when I come to a concrete case. So I think if our reports and criticisms can make concrete demonstrations of our cases instead of assertions, we shall be doing our duty to Homeopathy.

RUDOLPH F. RABE: In part answer to the remarks of Dr. Moffat, I may say that I think, in demonstrating our cures, we have one very good guide in proving that the improvement following the administration of a remedy is a true cure, and not a mere getting well. I believe we have to distinguish between cure and recovery. I believe in that firmly, but if we see, after the administration of the homeopathic similium, the homeopathic remedy, truly homeopathic to the condition, to the patient—if we see that the symptoms disappear in the inverse order of their coming—that is an absolute guide to us, and tells us absolutely that that is a cure, and not merely a getting well. The truth of that was announced by Hahnemann himself—that symptoms disappear in the inverse order of their coming; those that came first will be the last to go; those that came last will be the first to go. You will not find that in a mere getting well or recovery.

DR. MOFFAT: But in acute and chronic cases both?

DR. RABE: Yes, sir.

E. B. NASH: The Chairman has appointed me to discuss every one of these papers. (Laughter.) I do not know whether I will or not, but I want to say in reply to Dr. Moffat, partially, that we are getting too much of this question, especially from the Allopathic school—"How do you know but that your patient got well himself?" And they are disposed to throw doubt upon anything that we may do, on the ground that we are not pathologists and do not understand diagnosis. If we do not teach just as good pathology and diagnosis in our colleges as they do, why, I want to know it. I am happily connected with one of the colleges, and I know that we have as good pathology and as good diagnosis taught there as they can teach, and we know whether our patients are cured, or whether they get well spontaneously just as well as they do, and we do not ask them to decide that question at all. I do not propose to put myself under their examination. I passed my examinations. I have been admitted to practice medicine, and I suppose I understand it as well as they do, and in some cases, I presume, much better; and so I do not ask them to pass upon our work, at all. We will pass upon our own work, and we know when our patients are cured as well as they do.

OBSERVATIONS ON THE HOMŒOPATHIC THERAPEUTICS OF TUBERCULOSIS.

GUY B. STEARNS, M. D.,
NEW YORK CITY.

In recent years no medical subject has been more written about than tuberculosis. Both the lay and the medical press have agitated the public mind over the Great White Plague, its etiology, its pathology, its prevention and its cure. A wave of education has arisen, which has swept away the older hopeless attitude of the inevitable doom of the consumptive, and brought in its place a realization of the possibilities of cure. It has also brought an appreciation of the inter-responsibility of the patient and the public, in regard to the prevention of its further spread.

This new movement has come about from a better understanding of physiology and hygiene. It had its origin in the determination of an occasional consumptive who, in spite of an adverse prognosis, determined to live. He accomplished this by getting close to nature and living out of doors.

Because these consumptive pioneers selected certain localities

for their experiments, those regions acquired a definite curative reputation for tubercular cases. As a result, these places have been overrun by an army of invalids, who accepted more the detail than the principle of the cure. Among these have been many without money enough to support themselves during the time that is necessary for a cure. This has necessitated a warning for such not to leave their homes, and in order that the hygienic treatment may be utilized by them, roof and window tents have been devised, and the results are equally as good.

The open-air treatment has been combined with dietetic measures, which will furnish an excess of easily assimilated and highly nutritious foods.

An analysis of all this reveals a treatment which has for its object the régimé in life which all individuals should approximate, and which, if universally adopted, would do away with much of the sickness of the world. It belongs to the branch of medicine where generalization is possible, since it applies to the general laws governing life and nutrition, and in its application requires no special individual differentiation, because the general laws of hygiene are the same for all individuals. But it does not include the individual differences of constitution.

All investigations and experiments in the therapeutics of tuberculosis, as applied to internal medication, have been along the same general lines; *i. e.*, the fitting of a remedy to the disease or condition. And because no specific has thus far been found, nor appears likely to be, the profession, almost as a unit, regards drugs in tuberculosis with an agnostic mind.

At the recent tubercular congress held in New York city, Dr. Jacoby did decry the attitude of the medical profession toward drugs in tuberculosis, and expressed his faith in their efficiency. The drug he recommended, guaiacum, was in the nature of a specific, which he gave as a routine prescription to every patient. All others had to do only with the palliation of the cough, bowel conditions, digestive difficulties, sweat, etc.

In so far as the hygienic treatment is concerned, there can be no school of medicine. The laws of physiology are fairly well agreed upon, and the factors necessary to life are matters of common knowledge and acceptance. But the predominant medical aspect does admit of a wide variation in opinion. If there was no law by which drugs could be selected, there would be ample excuse for relying only on those principles which are known, and for casting aside that which is uncertain. But for the homeopathic school there is no such excuse.

This disease bears the same relation to vital force as do all other diseases, in that it produces a deviation from the normal, which is characterized by a definite symptom complex. It differs from the acute diseases, in that it is not self-limiting, and from ordinary chronic complaints, in that it does not remain quiescent, but its tend-

ency is constantly deathward. But it is like all other diseases, in that its cure depends entirely on the resistive powers within the body. And there is no inherent reason why remedies chosen according to the totality of the symptoms should not influence the tubercular patient beneficially, as well as any other. The reason why the Homeopathic School as a whole does not maintain a more decided attitude in this matter, is because it, too, is hunting for a specific, and is too frequently led to prescribe only for the most prominent or distressing symptoms, or to consider the disease from the purely pathological standpoint. A study of every case of tuberculosis will reveal a run-down condition of the patient for some months before any signs of the disease present themselves. When taking the history of a patient, not only must all the symptoms present at the time be recorded, but also especially those which occurred during this prodromal period, and even for years before.

The history, when written out, should include the patient's habits in all particulars and relations; the appetite, his desires and aversions; reaction to weather conditions, heat, cold, etc.; aggravations and ameliorations as regards time of day, seasons, localities, etc.; character of sleep and predominant mental conditions. The modalities of all symptoms, both past and present, should be ascertained most minutely. After all these, together with the existing symptoms, have been recorded, the case is then in a condition to be studied, and the nature and direction of the disorder can be grasped, from the first change of function to the ultimate tissue changes. With such a picture before him, the physician, from his knowledge of drugs, will be able to judge whether or not it will be safe to begin with the remedy which most closely covers the whole case, and thus run the risk of causing too great a reaction, or whether it is better to give a less deeply acting one, and go toward a cure more gradually. That there is danger in giving some of the deeply acting antiphorics in advanced tuberculosis, has been demonstrated too frequently to be a debatable question. Pre-eminent among the remedies which should be used with caution are sulphur and phosphorus. Many times have I seen such cases improve symptomatically under one or the other of these remedies, the cough becoming easier and the expectoration freer, but there followed a rapid loss of flesh, and speedy death; a true euthanasia. Paradoxically, the remedies killed the patients while curing them. When I was an interne in the tuberculosis hospital, I observed several times, when changing the treatment of a ward from that which was mostly palliative, to a careful working out of the cases homeopathically, an immediate increase in the death rate for a short period, followed by a long period of comparatively small death rate. Subsequent observations have led me to believe that, although the cases which die so quickly are already beyond cure, a wiser selection from the less deeply acting remedies which cover only a few of the most distressing symptoms, would keep the patients alive longer. Tuber-

culin is a powerful remedy, but is not a specific, and should not be given as a routine measure. Even if indicated, the doses should be infrequent. I have seen several cases improve for a short time on daily doses, and then get suddenly worse and soon die. In nearly all of these the kidneys suffered, the urine became albuminous, and contained pus, kidney epithelium and casts. Probably the nosode caused a too rapid unloading of toxic products into the blood. I have never seen such a result from doses given infrequently.

Among the most important remedies in tuberculosis, but one which has not the prominence which it deserves, is Kali carb. I think this remedy was much better known and oftener used by the earlier homeopaths than in these days. Hahnemann said that nearly every case of ulceration of the lungs needed this antiphoric before it would get well.

A review of the most useful remedies in tuberculosis would include all the deeply acting tissue drugs; and to give their special indications would be to write a materia medica.

But the curative remedy is not always found among these. In one case, which I have reported in another paper, bryonia cured. This patient had been ill for a year. I made no change in his method of living, because he was always out of doors as much as possible.

In another case, a nervous, hysterical young woman, ignatia cured. Her family history was bad, but the disease had only manifested itself for a short time though her sputum contained more tubercular bacilli than any I have ever examined. The symptom which led me to study ignatia was the character of the cough. The more she coughed the more she had to. The rest of the symptoms also corresponded with the remedy.

The difficulty in prescribing is in first getting a perfect record of the case, and then in knowing which are the most prominent and peculiar symptoms. Those which have to do with the general functions of the patient, as outlined in a previous paragraph, always rank of the highest importance. Any definite cause is always a valuable leader. In one case, where sexual over-indulgence was one of the factors, phosphoric acid was of great use, and prepared the way for tuberculinum, which cured. In another, the patient received a wetting, from which he took cold, and then developed tuberculosis. This led to a study of rhus toxicodendron, and it was found to correspond with all the other symptoms, and it cured the case.

No detail in taking the history should be neglected, and the questions should be asked as carefully, for bringing out each point, as a lawyer cross-questions a witness. Then, a careful analysis of all the data will reveal the characteristics which are peculiar to the individual himself, and enable the physician to select the remedy which has the closest affinity for the patient.

This method involves more labor and study than any other, but such individual work gives the tubercular patient the best chances for recovery, when combined with the general hygienic measures which are essential to the health of everyone.

DISCUSSION.

RUDOLPH F. RABE: I would like to say a word or two in relation to tuberculinum, which has been mentioned by Dr. Stearns. Tuberculinum, I think, is often charged with being given when not indicated, merely as a nosode, perhaps as a specific for tuberculosis. Of course, this is wrong, but personally I have seen tuberculinum do some very excellent work, not only in incipient cases, but in acute miliary tuberculosis, which of course, as we know, always terminates fatally. Here, the remedy seems to act as a great palliative, and the symptoms which I rely upon, to mention some of them briefly, are these: A feeling of emptiness, or as though hollowed out at the epigastrium, very similar to, in fact, almost like, phosphorous; great irritability in the stomach, intense pain on taking the slightest food, with vomiting and retching; sleeplessness, and, of course, the cough, which is hacking in character; and then, with all these symptoms, there is a great desire for cold air. The patient cannot seem to get enough of cold air, will want the windows wide open, and if possible, will want the cold air blowing right on him. In addition to that, there is often a history in these cases, and that you will find, in the incipient cases, of a sensitiveness to weather changes, particularly damp weather, with rheumatic symptoms. Those symptoms I have verified, each and all, and have found them to be reliable. In the acute miliary cases, tuberculinum has palliated wonderfully for me, and I give it in the 200th potency, made on the Skinner machine, from the tuberculous glands of a cow, and done under federal control; and that tuberculinum I have found to be the most reliable preparation.

GEORGE F. LAIDLAW: The subject of tuberculosis is always a serious one, and I think we make a mistake to take it so lightly as we do. Now, we homeopaths are apt to have a notion that if we can get our simillium, we can cure everything. I notice on our program a case of epithelioma of the tongue cured by internal remedies, which I have no doubt occurred. The Doctor has related cases of tuberculosis which have recovered by the use of the internal remedy, which I have no doubt occurred. But, gentlemen, it was my fortune some time ago to present this subject to a society of allopaths. There are gentlemen sitting in this room who were responsible for that invitation to attend the Practitioners' Club of Yonkers, and present the subject of the treatment of tuberculosis from the Homeopathic point of view.

Now, gentlemen, the problem was before me as to how I should

present that subject from the homeopathic standpoint to a society of allopathic practitioners who were not interested in the law of similia, who were not interested in our technique. What should I tell these men, honestly, that we homeopaths could do in tuberculosis? That proposition I would like to see some other man answer. It was rather difficult for me to know what answer I should make, what answer a self-respecting homeopath should give to that question, 'What can a homeopath do in the treatment of tuberculosis?" Should I stand up there and tell them of a series of cases that had gotten well? Perhaps they would point out to me —there were a dozen homeopaths in the room—that such and such a man's cousin, another man's uncle, another man's sister, had died of consumption in that very town, and that they remembered their funerals going down street. Should I tell them that we had a specific for tuberculosis with which we could cure cases right straight along, one after the other? I should have had before me the figures of the two homeopathic physicians whose children I knew had died of tuberculosis, though they had had very good men prescribe for them. Should I take the position that if we only worked long enough on our materia medica, and only knew our symptomatology well enough, and had plenty of patience with our cases, we could find the similium and cure the cases? Well, Farrington was a pretty good homeopathic materia medica student, and Farrington died of tuberculosis; and skilled homeopathic physicians, I think, were prescribing for him. Now, what position will we, as a Society, take toward the cure of tuberculosis? I do not think, when we contemplate the facts that we see around us, as they are in many families whose members have died, that we can take a very hopeful view of our ability to cure tuberculosis by our internal remedies. Well, the situation that confronted me was one in which I had to put the best face on the matter that I could. I took the position that we were dealing with a certain malignant disease which was not under the control of any medicine, not yet under the control of specific medication, and no more under the control of the homeopathic remedy than one of their remedies, any more than were carcinoma and sarcoma, in a specific sense; that we homeopaths could not present them with a specific remedy for tuberculosis, any more than they had one themselves, as was freely admitted by the previous speakers, Dr. Meyer, of the Montefiore Home, the Health Commissioner of New York, and a doctor who represented Dr. Russell's motion treatment, a post-graduate, and another physician. I took the position that the cure of tuberculosis involved the building up of the patient's vitality, that it was hopeless to try to kill the microbes. We have given up all that, trying to kill the microbe with creosote, and I am happy to say that that particular fallacy I never was guilty of. I put my appeal to them on this ground—that what we should do is to build up the vitality of the patient to resist the attack of the microbe; that in that lay the successful

treatment of tuberculosis. Here was a body of physicians who for more than a hundred years had held that there must exist the food stuffs, either the fats or the other principles of food, some element which the patient lacks. Dr. Russell took the position, in relation to vegetable juices, that there must be some food element that meets the conditions, as some patients get well so quickly on that; and as on the others it has absolutely no effect, there must be some other food element that these cases lack that do not get well. So he crushed up all sorts of vegetables and fed them to his patients in the effort to get the element that the patient lacked in order to build up the vitality to resist the invasion. I said, here was where Homeopathy came into the question; we homeopaths had been studying patients for many years; for a hundred years had been studying the human organism, taking down its symptoms, studying its diseases, to determine what particular organism lacked sulphur, what particular organism lacked phosphorus, what particular organism lacked calcarea, what a given body lacked that would give it resisting power to throw off the invasion, and that was where the homeopathic materia medica came in. We had no specific for tuberculosis. Many of our cases died. I did not have to tell them that. They had seen the funerals going down the street as well as anybody; they knew the family history of the homeopathic doctor sitting beside them, and who had died and who had not. You couldn't jolly them, you couldn't tell them fish stories. You had to tell them the absolute truth. That is where we come in—the building up of the resisting power of the patient by selecting out of the symptomatology the lacking element in the constitution. Now, that was the best face I could put on that for the homeopathic cause before a society of intelligent men, and I am sorry to say that that is the best face, I think, any of us can put upon it. We cannot fairly take any other position in our societies with Farrington's death before us, with the deaths in our families before us, with the deaths of our own prescribers before us. We can take early cases, and some of them may get well.

I only want to close with one thing, as establishing my reputation as being familiar with homeopathic literature. I think Dr. Stearns has misquoted my old friend and hero, Hahnemann. He states Hahnemann's words to be, that very few cases of ulceration of the lungs get well without kali carb. If I remember correctly, the wording of that sentence, it is, "it is almost impossible for any case of ulceration of the lungs to get well without kali carb.; which seems to me a statement that is not well warranted, because we have many, many cases of tuberculosis get well without any kali carb. at all.

RUDOLPH F. RABE: I do not think we homeopaths can be charged with trying to tell fish stories or give "jollies" in a matter of this sort. It is a very melancholy matter, a very serious matter. I do not think we can be charged, especially we Hahnemannians, as we are called, or the high potency wing, so called, with claiming

to cure all cases of tuberculosis, or even very many of them. I myself state that patients with acute miliary tuberculosis invariably die. I have never seen one get well. We must take that into consideration. But I think my friend Dr. Laidlaw perhaps labors under the same delusion that I tried to point out in my paper, that the remedies must be related to the disease. They cannot and they never will be, and the explanation of the final cure of tuberculosis does not rest there. In New York at the present time we have in our own college a man who is taking part in a line of investigation particularly in regard to carcinoma and tuberculosis. Perhaps he may solve the problem; perhaps he may not, but he is working along the line of new and untried remedies in potencies of 1x and 8x, as he has them potentized. Now, that has yet to be proved upon the healthy human being and tested clinically, and if we ever find the solution of that problem, it will be along the line of pure Homeopathy, and not along any other.

E. B. NASH: This is a very interesting subject. I am glad that Dr. Laidlaw was called before this Society to give his reason for the hope within him. Speaking for myself, I should not really expect to satisfy a body of men who treated disease as an entity, instead of treating patients who were sick. There is so much of that work done in routinism, and it is not true homeopathic prescribing. Dr. Laidlaw says particularly that there is some element lacking in the system; that one man gives oil, another gives the vegetable treatment, to supply some lacking element. Now, why that lacking element? Simply because nature is not performing her function. If we can remedy by our symptomatically indicated remedy, as we do in other diseses, the condition which leads to that lack, nature will select its own elements from the food we eat every day, and that other people get their elements from. It runs right back to this, that we must meet the disease in its "dynamis," as Hahnemann used to say, or its "meanings," as I may term it, by the vital force or dynamis that resides in the drug. If the pathological changes are too great to meet there, and have taken place to such a degree that it is not possible to cure the patient, all we can do is simply to make the patient more comfortable with our homeopathic remedy. There is no such thing as treating phthisis pulmonalis—tuberculosis—as an entity. It is simply sick physiology; it is simply a perturbation of the vital force, turned out of its course and weakened so that it cannot repel the inroads of these microbes, which will attack nobody but that is attackable. So far as the results are concerned, I am perfectly satisfied myself, after long observation, that we can do with our homeopathically indicated remedies in the incipient stages of phthisis pulmonalis what the Old School cannot do, and the fact that they invited Dr. Laidlaw there to give them our process of treating homeopathically this disease, shows that they are not satisfied with their own success, and perhaps not so well satisfied as we are; because I am convinced

after observing their cases treated with creosote and those microbe-killers, that the Doctor credits them with having gotten rid of—with having gotten over all this idea—I think, if you should go back in the country, you would find them, as I do, still filling their patients with creosote and other microbe killers. I am convinced that the only thing, and the best thing, upon which we can rely, is the homeopathic remedy, with any hope of success.

FRED D. LEWIS: This is entirely away from my field of work, but I do not want to let the discussion pass without saying a word or two. I do not believe that in the treatment of any disease we can depend entirely on our materia medica. We must look to sanitary conditions, we must look to the surroundings of the patient. I was very much interested a short time ago in a discussion with a prominent Chicago oculist, an Old School man, who had been to Colorado and made a little experiment with half a dozen tuberculosis patients. It interested me very much. He took these patients and put them into a Japanese tea house, with an open roof under the clear sky, where they were breathing the pure Colorado air, and gave them reading matter, allowing them to read all day long, and eat their meals and get a little exercise. Yet he found night sweats, high temperature, hectic flush, day after day. The week following he took the same six patients out for long walks where they looked long distances over great spaces to distant mountains, engaged them in conversation, and after the second day the temperature lowered, the night sweats and hectic flush reduced. He held, and I am inclined to think he is right in the matter, that in the use of the ciliary muscle, or muscle of accommodation of the eyes, in a tubercular patient who is kept at home and has nothing else to do but read, there is a waste of nerve energy in the effort to see, to such a degree that it permits the further progress of the tuberculous disease; whereas, if relaxation of the ciliary muscle can be obtained by looking long distances and by refraining from close application, we will get a better result.

JOHN L. MOFFAT: I would like to say that Hahnemann himself teaches the removal of all the causes, and if these six patients happened to be presbyopic or hyperopic, maybe they would be improved by relief of the strain upon the eyes. Six patients, however, one week, is merely a little tentative attempt at an experiment. It seems to me that we are not so far apart, and I believe that very soon we shall be able to attract and hold the attention of the Allopath even better, if we take the position outlined by Dr. Laidlaw, that when you come to choose the homeopathic remedy, if it is the right one, you raise the index of the blood—let us get right down and talk intelligibly, so they understand. I do not talk anything about potency. I talk first about the fact of choosing the remedy, and they will listen to us more and more if we are willing to talk in their terms to a certain extent, and then we will introduce our own terms. I do not recollect at this moment ever hav-

ing heard of an allopathic doctor making an honest study of Homeopathy, but that he was converted. I think I have heard of allopathic brethren, who thought they had studied Homeopathy, or thought they had been told something about Homeopathy, and didn't care for it. Maybe they had not given it a fair enough, or a long enough, or an intelligent enough trial. We are not obliged to go before them. We are going straight forward, and we are winning their respect, but with the twentieth century I want to win their respect for our new ways as well as our old ways. I think the homeopathic experiments being undertaken in the London Hospital are invaluable to the future of Homeopathy, where they are testing the results scientifically.

A CONSIDERATION OF THE RELATIONSHIP WHICH OUR MATERIA MEDICA BEARS TO THE TREATMENT OF DISEASE.

RUDOLPH F. RABE,
NEW YORK CITY.

For centuries it has been the endeavor of physicians to cure *diseases* until the so-called rational medicine of to-day consists of the accumulated mass of experience and empiricism directed at *disease* itself. This, with the wonderful advances made in methods of diagnostic precision, pathology and bacteriology, has come to be considered a fixed entity, largely, if not entirely pathological in character, toward the removal of which all the therapeutic means in our possession should be directed.

To the homeopathist, with his law of cure as an unfailing guide, disease, on the other hand, is considered as a distunement of the vital force proceeding from centre to circumference, from within outward, from man himself to his organs and parts. Disease as thus understood manifests itself by symptoms and signs by which the sick man himself is recognized. Pathological changes in tissues and organs are the results of disease, and in no way to be considered as the disease itself. The study of Pathology, *i. e.*, morbid anatomy or tissue change, is of great importance in the recognition of disease, results, or end-products; hence, diagnosis or labeling. Diagnosis practically means to affix the label. Labels are the medium of exchange used between physicians in discussing and describing cases. Often the labels are the wrong ones; hence follow discussions and faulty conclusions.

If, now, the treatment of disease depends upon the label, *i. e.*, the diagnosis, it follows that it must be directed at the pathological

state or tissue change; hence, the results only of disease are aimed at, while disease itself, in its essence, is entirely overlooked. Granting now the patent fact that faulty diagnoses are often made, in other words that the wrong label is frequently applied, treatment adapted to the faulty diagnosis must as a natural consequence, be also faulty. And so we find it in the so-called medicine of experience, the old school, and in the pathological wing of our own. Physicians imbued with such false philosophy constantly overlook the sick patient himself in their anxiety to cure his disease. In consequence, Homeopathy is many times blamed for a failure which should more properly be laid at the door of the physician and unhomeopathic measures, directed at the disease itself, and in no way related to the patient, are employed. Thus, we are told by physicians, that Homeopathy, in their hands, has failed miserably in desperate cases, such as the terminal stage of a chronic endocarditis, with its broken compensation and resulting dropsy, dyspnœa, and all the usual train of conditions which follow. That in such a case heroic measures are absolutely necessary, that active stimulation is in order, that diuretics to carry off the accumulated fluids must be given. This practice is by them considered to be scientific, and being scientific, not only justified, but actually demanded. What, then, is the truth? Simply this, that the sick man himself, the man back of his organs, has been overlooked. The signs and symptoms which characterize the man have been neglected, and instead, the gross results of his disease have been assailed. To be sure, it may be frankly conceded that the time for cure has long since gone by. If this is so, the fact may be easily recognized by the careful observer, trained in homeopathics, by the entire absence of any individualistic symptoms; symptoms, as stated above, which characterize the man himself, and on the contrary by the presence of pathognomonic symptoms only. In such a case, homeopathic palliation, than which there is none better, is now in order, and leads, not only to the comfort of the patient during the small remainder of his life, but to peaceful euthanasia at the inevitable end. Is there any death more distressing to witness than that mistakenly postponed by the use of powerful drug stimulants, until even these are no longer able to stave off the awful struggle they have in reality induced?

If, however, cure in such a case still be possible, it can only be wrought by treating the man himself and neglecting the pathognomonic symptoms. The more important these are for making a diagnosis, *i. e.*, affixing the proper label, the less valuable do they become as aids in treatment; *i. e.*, selecting the remedy. The latter, like as not, is one which has never produced or been known to produce a similar pathological state, though it is not denied that it may perhaps be capable of doing so; but in its pathogenesis reveals a drug genius corresponding closely to the individual genius, peculiarities and characteristics of the patient himself. In the hunt

for the simillimum it may be necessary to search away back for the beginnings, the earliest manifestations, often in themselves quite insignificant, yet showing the direction in which events are tending. The remedy corresponding to these early symptoms will many times be found to be the one now required, and which if given at this early period, would have entirely obviated the need for its employment now. As an example may be mentioned the case of a woman suffering from a uterine polyp. She is phlegmatic, stout, suffers from profuse, prolonged and too early menses, and perspires readily upon slight exertion. Her early menstrual history shows much the same condition, though no morbid growth in the uterine cavity was then present. The tendency to easy sweating existed always, and as a child manifested itself in profuse occipital sweats during sleep. The remedy was, long has been, and is now, the deeply acting antipsoric, Calearea carbonica, but having never been applied, this woman's vital force, flowing unchecked in inharmonious manner, from centre to circumference, has ultimated in the present pathological state. Remove this present state, this pathological end-product, by surgical or other unrelated measures, you by no means cure the woman, whose economy has not been placed in harmony and order. But cure the patient first, and then, the pathological outgrowth still remaining, surgical measures may now with safety be applied.

This conception of disease and its cure is the only one possible to the mind trained in the philosophy of Hahnemann, the only one which enables the physician possessed of it to rightly distinguish between curability and incurability, between recovery and cure, between disease suppression and disease removal, and lastly, between disease itself and disease results. Practice based upon this conception is the only practice in accordance with the principles of Homeopathy, gives a broader definition to Pathology itself, and, although admittedly difficult to follow, yet being based upon the only true law of cure—Similia, Similibus curantur—is both scientific and successful. Therefore, the true relationship which the Materia Medica bears to the treatment of disease is simply that between remedies and patients, drug-symptoms and symptoms of patients ill. In this manner, diseases are cured by curing the patients in whom they are manifested; for since symptoms are the outwardly reflected image of the inner nature of the disease, *i. e.*, of the suffering vital force, and since symptoms of patients in sickness correspond closely to symptoms of patients artificially made sick by drugs, *i. e.*, provings, it follows that disease symptoms and drug symptoms are interchangeable, hence, closely related. This close relationship, then, is the true and only one which exists between disease and materia medica, and the proper conception of this relation is absolutely vital to the Hahnemannian physician.

REPORT

OF THE

BUREAU OF NEUROLOGY.

"Constitutional Inferiority," - - - - - FREDERICK C. ROBBINS.
"The Unfortunate Borderlander." - - - FREDERICK W. SEWARD, JR.
"The Control of Cases of Addiction," - - - - JOHN T. GREENLEAF.
"Are The Violet Rays a Cure for Paralysis?" - - W. E. MILBANK.

CONSTITUTIONAL INFERIORITY.

FREDERICK C. ROBBINS, M. D.,
GOWANDA, N. Y.

It is a very evident fact that in the examination of large numbers of the insane, one finds many stigmata of degeneracy.

While it is admitted that everyone is allowed a few tell-tale stigmata, one cannot but be impressed, on examining a case with marked physiological defect, that the same was to some extent the basis for the psychosis.

In the imbecile and idiot the signs are markedly evident, but in many cases the signs, while not so conspicuous, are very plain to the trained eye.

There can be no doubt that individuals presenting such stigmata have low resistive forces, are more easily impressed by certain things, and have a lower moral tone; in short, very poor stability.

The student cannot but be impressed with the fact that there is some reciprocal relation between the physical degeneracy and the general personality. On examining a new case presenting marked stigmata with many of the symptoms of one of the psychoses, one is often at a loss how to classify such a case. Is it a case of manic depressive, dementia præcox or involution melancholia, according to the symptoms, or is it a case of constitutional inferiority (as we call it in the classification adopted by Dr. Adolph Meyer, of the Pathological Institute of the New York State Hospital service)?

If there are no clear-cut symptoms, and there has been no apparent pronounced etiological factor outside of the physical degeneracy, the patient being of a rather fair intellectual standard, able to do business, care for himself, but often reacting to what must be a deficient mental make-up, one cannot but feel that it is a case belonging to the constitutional inferiority class.

Where the case presents marked flight of ideas, retardation and depression, why is it not a manic-depressive episode on a constitutional inferiority basis?

We find that the range of intelligence is decidedly limited, and there seems to be a point in the educational sphere beyond which they are unable to go. Their knowledge of current events is very ordinary, and on the whole they are what one might call shallow. The cases I have seen are quite emotional, and as children they were those who insisted and did have their own way, being beyond parental control. As regards their moral stamina, to a great extent it is undeveloped; while they will deny, often very angrily, any deviations from social and moral ethics, we find that in many cases there is a complete lack of morality. They are, as Defendorf says, "Moral Imbeciles."

If we examine into these cases carefully, we find some marked hereditary factor, such as a bad temper, extreme nervousness, symptoms of neurasthenia, hypochondriasis, undue irritability or some abnormal deviation from the ordinary normal equilibrium.

Everyone who is not equal to, or is not superior to, his forebears, is certainly retrogressing; and there is no doubt that in cases belonging to this group such is the state of affairs.

As we examine very carefully into the family history, one cannot help being impressed with the fact that physiological stigmata must enter, to some extent at least, and in many cases to a considerable degree, into the mental make-up of the individual.

The anatomical signs vary to a great extent in different individuals; there may be a decided abnormal development of the cranium, a lack of proportion, as is often noted in the criminal. The face may show much asymmetry, viz: The eyes being of the mongol type; increased or distorted growth of eyebrows; ears defective in position and size, and lobules are apt to be adherent; palate may be high and narrow, or low and saddle-shaped, sometimes presenting a longitudinal torus; the teeth may be defective, second dentition being incomplete.

In several male patients have been observed enlarged mammary glands, absence of hair on body, and soft voices, while in women have been seen increased growth of hair on body, and voices approaching the masculine. The cases are often sexual perverts in some form; are inclined to masturbate to a more or less extent, and the men have abnormal nightly emissions.

It is often a great question what the normal condition of an individual is or should be. What you or I would call queer or odd, others might call normal. We often have relatives visit patients and say to us that the patient is as well and acts as he or she always did, while to us they seem far from a normal standard. In such cases we have to discharge them recovered to their normal condition.

The first case I present is that of a young woman who twice attempted suicide on the streets of Buffalo; a case which was a

puzzle to the police. She, having no one to care for her, and unwilling to be influenced by relatives, was sent to the hospital for treatment. Before she left, she admitted to one of the physicians that for the first time she had learned the meaning of the word "discipline." While her hospital experience has benefited her, she will no doubt return to her former habits, being of a very erotic temperament and one who is controlled by her impulses.

Admitted June 5, 1906. Age 29. Widow. U. S. Skirt maker. F. H. Father is of a very nervous temperament. When the patient was a child he would become very angry at her, and would often knock her down on the floor. Mother is also very nervous and rather erratic.

P. H. Patient born in Cherry Creek, N. Y., Nov. 4, 1878; began to attend public school when six years of age, and attended same until 20 years old. Had the ordinary childrens' diseases—measles, chicken pox, mumps and whooping cough. At 16 years had anæmia, which condition lasted for two years, after which she entered Buffalo Normal School; was there four years, but did not attend regularly, and finally decided that she did not care to be a teacher, so went and worked as nurse girl for her sister; became dissatisfied and, as another sister was an actress, decided she would like to be one also, and ran away, not telling where she was going. Traveled for two years "starring." During that time she met an actor whom she married, but lived with him only three weeks, as she found he was not true to her. Becoming tired of the stage, she went back to Buffalo, and became a skirt maker for a clothing firm.

Psychosis.—When a child, patient had a very vicious temper; when she became angry would throw herself on the floor, kick and scream, throw things about, and at times would bite herself on the arm. Of late years has confined herself to screaming and throwing things about when she was opposed and could not have her own way.

During the Pan-American year had considerable insomnia, for which she took chloral, and one day she took an overdose, from which she was quite ill. For the last year, patient has been going about with a physician who was engaged to be married to another young lady. Patient admits that he gave her money at various times, and made her some indefinite promises of marriage. In February, 1906, having bought some laudanum, she went down to his home, drank the laudanum out on the sidewalk, threw the bottle down, went into the office and said she had come to say "goodbye." On being questioned, she told what she had done. The bottle corroborated her story. . Several physicians were called, she was given heroic treatment, and made a good recovery with no ill effects from the drug. This matter was hushed up, and she became more intimate with the physician, but he would always put off marrying her, although at one time they were going to elope. On the 3d of June, 1906, she bought some laudanum; had some difficulty in pur-

chasing same, but finally at one store, in reply to questions, she said she wanted it to put in a poultice, and was given two ounces. On the way home telephoned to a physician and asked him to tell the physician with whom she was going that she was about to do some harm to herself, and several hours afterward drank the laudanum and went to bed. In a short time the physician she had telephoned to came in, and she told him what she had done. He immediately sent for two other physicians, who lavaged her stomach and sent her to the General Hospital. While there cried a good deal, and was at times very hysterical.

On admission: Was crying very loudly. Said she was not insane, and did not want to stay; was quite resistive on being taken to ward.

Her height was 5 ft. 7 in., weight 155 lbs. Hb. 80%; well-developed, heavy features, pudgy in appearance, face small, nose broad, ears large; palate high and broad with marked torus; chin a trifle receding. Cephalic index 78.23; expression of eyes dull; dermographia slow in appearing and faint.

Well oriented as to time, place and persons. Memory of recent and past events very good. No delusional or hallucinatory condition. Educational tests very good. Denied attempting suicide, in fact, fabricated about all her past life. Insight good, judgment poor.

June 12, 1906. For the first week after admission was very resistive; would not conform to hospital rules, and would cry and scream when she found she had to obey.

June 17, 1906. Up and dressed. Sits about ward, taking no interest in surroundings, appearing very apathetic, often noticed with eyes fixed, perfectly oblivious to what is going on about her.

June 25, 1906. Discussed past. No intention of committing suicide now, previous attempt being for effect only.

July 4, 1906. Exhibition of temper.

July 10, 1906. More cheerful. Working about ward, though reluctantly.

August 16, 1906. Very good self-control. Paroled for 30 days, at the end of which time she was discharged recovered to her normaml condition.

The second case is one of manic-depressive on a constitutional inferiority basis. This patient, a young man, showed such marked stigmata of degeneracy as to suggest that the mental condition was an episode on a defective basis, there being an utter lack of shame, inability to distinguish between truth and falsehood, and success in no occupation. This patient became the despair of his parents on account of his alcoholic excesses, and finally was committed as a last resort.

Admitted Oct. 24, 1906. Age 26. Single. U. S. Clerk in Bottling Works.

F. H. Paternal grandfather died of general paresis. Maternal

grandfather died of Brights' disease; a paternal uncle died of spinal meningitis, and a paternal aunt died of a cancer.

P. H. Patient was born in Salamanca, N. Y., May 14, 1880; attended public school from the age of 7 to 15 years, at which age he went to work, remaining only a short time in a place, as he would either be discharged for negligence or would leave on account of being "tired" of the place. Of late he has worked for his father in a bottling works as clerk.

Psychosis.—In 1898 patient was in Providence Retreat, Buffalo, for several months; he had been masturbating a great deal previous to admission, and had developed delusions of persecution, and had considerable depression and insomnia; also physical condition was very poor.

Patient gradually improved mentally and physically, and was discharged recovered.

About January, 1905, began to use alcoholics, and in a short time became a confirmed toper, in addition to which he also masturbated to a great extent and smoked cigarettes constantly. He gradually became untidy in his personal appearance, was very ill-natured and began to neglect his work. The family attempted to restrain him, but he became more ugly, and would threaten suicide if not given money; said he would hold up a train and threatened his parents when they remonstrated with him for going out during the night to buy whiskey.

On admission was quiet and orderly; realized where he was, but appeared apathetic, taking little notice of what went on about him. His height was 5 ft. 9¾ in., weight 132 lbs., Hb. 80%. Cephalic index 75.02; heavy features, protruding lips, nasal folds shallow, palate very broad with a marked torus, ears prominent, inguinal glands enlarged; eyes of, mongol type, winks almost constantly expression dull and movements slow; pupils slightly irregular, left being a trifle smaller; dermographia slight; reflexes diminished equally, with exception of knee cap, which is somewhat increased with Jendrassic; co-ordination fairly good; fine tremor of fingers; several times monthly has nightly emissions, and has been detected masturbating; much restlessness; pulse regular but of poor tension, and accelerated on least exertion; mucus present in urine.

Delusional condition negative; well oriented as to time and place; recalls recent and past events fairly well; retention poor; results of educational tests very unsatisfactory, although calculation and handwriting were very good.

For the first few days after admission he demanded whiskey, but on being denied, finally ceased.

October 31, 1906. Appetite ravenous, and he was more sociable.

November 6, 1906. More cheerful; doing light work and amusing himself with checkers and newspapers.

November 20, 1906. Since letter written home on the 16th he has been very surly. Letter ungrammatical and very poorly written.

November 30, 1906. Very quiet and good-natured; paroled for 30 days, at the end of which time he was discharged recovered to his normal condition.

THE UNFORTUNATE BORDERLANDER.

FREDERICK W. SEWARD, JR., M. D.,
GOSHEN, N. Y.

Progress all along the line, has been the rule in Medicine, and in no branch of our art more pronounced than in that of Psychiatry. For, whereas, formerly the subject of a mental disorder was regarded as beyond the reach of assistance and was dealt with as a foe to society at large, as an evil to be shunned or guarded against, and was, therefore, incarcerated and treated with even more rigorous restraint than a criminal, now we have come to regard his malady as related to physical disorder, and have been able to classify and distinguish the functional and organic nature of each individual case, and to apply measures which restore or alleviate.

Nevertheless, while such advancement has been made in the direction of a better knowledge and treatment of mental cases, much remains to be done, especially with reference to the civil and legal management of these cases. For, when a mental aberration becomes pronounced, it is illegal under existing laws for the subject of such disturbance to be cared for, outside of his own home, except under a formal commitment as an insane person. No degree of insanity is recognized, or rather, no *distinctive* degree; no classification is made or attempted. The object of such commitment is to secure the rights of the patient, who is irresponsible, and to make his detention and forceful restraint, if required, legal upon the part of those charged with his custody, care and treatment.

At this time, when we understand the varying degrees of insanity; when we know that many cases, especially of an acute and functional nature, are passing frequently across the borderline of rationality, sane one hour, violently excitable and insane the next; when we appreciate the exquisite impressionability of some cases of emotional or hysterical insanities, and realize how strictly must such a subject be sequestered and safeguarded from all exciting or disturbing influences, we can understand how fatal to their interests must be a formal examination and commitment made in accordance with existing legal requirements before suitable and requisite steps can be taken to place or hold the subject under proper conditions to secure their best interests.

The fact is, up to this time our law makers have given apparently little intelligent thought to that class of cases ordinarily termed

"borderlanders," nor to such institutions as have, from the very necessities of such cases, sprung into being within the past fifteen years. The insanity laws to-day refer more to the *custody* than to the *treatment* of the insane, and far more to the incurable class.

By "Borderlander," we mean one who is afflicted with a mental or nervous disorder which places him on the borderline of insanity. There are many such patients and they deserve most careful and thoughtful consideration. As the law of this State now stands, this Borderlander is not recognized or considered. A person is either sane or insane. If sane, all well and good; but if he shows a slight degree of mental confusion, or manifests some harmless and mild delusions, even though his mental state is obviously a transient one, he is classed as an insane subject along with the paretic and the demented insane commonly seen in our State institutions.

Let us imagine a case of a young woman of excellent standing and character, who is pursuing a literary course for her living. She is more or less widely known by several books she has written, and intends shortly to publish another. She meets with a very sad and shocking death in her family, and, being already in an overworked and poorly-nourished condition, she suffers a collapse. Her mind, too, gives way, and physicians are called, who in turn call specialists, who determine that she should be removed at once to a private sanitarium. This is done, and after a few days of careful treatment and observation, the physician in charge declared that she will in all probability make a good recovery in the course of a few weeks, and that her mental condition will probably clear up in half the time. The patient is neither suicidal nor homicidal, nor indeed, is she anything but a sick woman whose mind is temporarily clouded. She may have lost interest in things; does not care to eat or to walk, nor has she the least desire to read or write. Perhaps she weeps, and is depressed. Is this person insane? Let us say she is mentally exhausted, and to that degree she is insane. Admitting this, how should the State treat her? As a demented, hopeless subject, incompetent of doing a thing other than to vegetate and live a negative life? Surely, if she has a good chance to recover, we have no right to brand her as we brand the hopeless dement, for by doing so we would deprive her, in part, at least, of her means of earning her livelihood. Yet the law of our State says no physician shall treat, in his institution, an insane patient unless that patient is duly committed as provided by law; yet that act of commitment brands the patient with the same brand we used for the hopeless dement. I submit that such a case should not be considered in the same class with the hopeless dement and the violent lunatic, but that the law should either permit reputable physicians to treat her without even raising the question of commitment, or it should provide a form of commitment which would not injure the patient's standing in the State, and more particularly in the community in which she makes her home. But our legislators are not physicians, and while they have probably done what they con-

sidered best, what they really *have* done, in relation to the borderlanders, is to refuse them recognition. Is it not the duty of the medical societies, through their committees on legislation to introduce the legislators to these unfortunate "Borderlanders?"

In place of the case of the literary woman above cited let us substitute the case of a dentist who, from an unfortunate financial venture, has a similar breakdown. Or, to bring the question nearer home, let us imagine the patient to be a physician who has been overworked, and who has a suit of malpractice brought against him. If this physician, after gaining considerable local notoriety because of the suit for malpractice, breaks down under the additional worry and, perhaps, some loss of patients and families, is it just and proper to brand this man as insane by committing him to a sanitarium for treatment, as you would commit a demented person to a State hospital? I venture that it would be more just and proper to pass some law permitting this unfortunate "borderlander" to regain his health without commitment or with a different commitment than that now in force, and, what is more important, to permit him to return to his home a well and strong man, in fit condition to live down his accident, without further burdening him with a record of insanity which may do him infinite harm.

Suppose the unfortunate borderlander to be your wife, mother, or daughter, and you desire to send her to a sanitarium, and you are asked to class her with the chronic insane in order that she may be treated.

In addition to the above considerations, which refer to the patient or the subject of an illness, there are others which refer to those of us who are devoting our lives and efforts to the proper care and successful treatment of acute, recoverable disorders of the nervous system, some of which are at times attended with mental symptoms.

As the law of the State stands to-day, we are compelled to subject these patients to the inquisitorial inspection of the State Commission in Lunacy, and ofttimes are obliged to see them subjected to examinations under legal process when, in our judgment, such inspections and such examinations are not only injurious to them, but may be destructive of all possibility of recovery.

I submit that this matter is of sufficient importance to be taken up by this society, and I would suggest that it be referred to the legislative committee; that they be instructed to give it due consideration and to report upon it at the next semi-annual meeting, and that they present some remedy if they find one needed.

This paper is not meant to cover the question, nor can it do it justice in the short time allotted. It is meant only to point out that a grave fault exists in our lunacy laws, and to call attention to the fact that there is a large class of cases which have come to be called "transients" or "borderlanders," and that they have absolutely no recognition by law, but are classed and treated as dangerous lunatics and chronic dements.

DISCUSSION.

C. C. HOWARD: This paper interests every man that is at all associated with the insane, and I think that it should take our careful consideration. We meet with any number of just such cases as the Doctor has described, and we do not know what to do with them. It is a shame, it is an outrage, to put them in an insane asylum, and yet our hospitals will not receive such cases. They have no provision for them. It seems to me that every hospital should have a psychopathic ward well equipped for just such cases, that they could be properly cared for and would not have to undergo the stigma of being put in an insane asylum.

M. C. ASHLEY: I have very few words to say on this subject. I recognize, however, the fact that the question is one of the greatest importance to all those so-called borderland cases which we call sometimes the drug psychosis. It does seem unfortunate that such cases have to be admitted either to private institutions or State institutions for the insane. The trouble is that many of them cannot receive adequate treatment in such institutions for the simple reason that the committing physicians recognize the fact that a man committed to one of these institutions as insane, deprived of his drug, his alcohol, for a few days, will clear up and become entirely rational and sane to all intents and purposes, and must of necessity be discharged because of there always being a difference between a man being medically and legally insane. It has been our experience that a great many patients have been committed to us in just that way. I believe medically they were insane, and medically entitled to treatment in some institution; men who had gone for years spending their time and their funds and their health in dissipation until they had gone to the extent of losing practically all self-control. They were a burden to themselves, to society, and useless. They were committed to us. As soon as the drug was out of their system they were again rational. No jury on the face of the earth would hold them as insane when brought before them on a writ of habeas corpus. They must be discharged. So, it would seem to me that there ought to be a law which would not brand them as lunatics, but under which they could be committed to some institution where they could be detained for perhaps a specific length of time. You cannot say, "until sane," or "until their delusions disappear," or "until they can convince a lay jury that they have delusions no longer, or are able to control themselves," but "until such time as those who have their case in hand consider them capable of exerting greater self-control.

FREDERICK W. SEWARD: I would like to make the formal motion that that matter be referred to the Legislative Committee; and, in addition, that it refer not only to drug cases, but to cases of hysterical insanity and all cases included in the term "borderlanders." The discussion seems to be directed more particularly to the drug cases.

H. WORTHINGTON PAIGE: Could not the speaker formulate some idea for the Committee on Legislation? To hand them this whole paper to go over, and the discussion, would be the only way at present in which they could get any idea as to what the subject was. Could not some one formulate a resolution from the paper, have that adopted and handed to the Committee to take some action upon?

FREDERICK W. SEWARD: I simply wanted to call their attention to it, Mr. President. That was all my motion was intended to do, simply to refer it to the Committee, and they are the proper ones to suggest what to do.

THE CONTROL OF CASES OF ADDICTION.

JOHN T. GREENLEAF, M. D.,
OWEGO, N. Y.

A man in mid-ocean, in an open boat and all alone, may be said to enjoy perfect liberty. A man in the middle of some of the great western plains all alone, with no one in sight, may also be entirely free; but just in proportion as either one of these beings approaches the shore of the boundless deep, or wanders towards civilization, he begins to be hampered and circumscribed by the rights, privileges and notions of others.

A speculator may buy a lot and build a house, but he must not set fire to it. A man may have a horse, but he must not abuse it. Anyone may marry and obey the Noachic precept, but he must not neglect his family nor waste that which would clothe, educate or care for his wife and children. A man may entertain and set forth to his neighbor any delusion he fancies. He may so distort the record of his senses as to fail to see things as they are, and as long as the domination of these fancies does not affect his social, domestic or financial life, he will not be molested; but let him, ever so slightly, begin to vary from a line of conduct that the conventional consensus of the society in which he moves and lives has approved and is practising, and he is at once pronounced insane, shut up in a place which may or may not restore him to mental and moral health, and his property is put into the hands of some one whose ability and honesty is vouched for by the courts.

Now, let the same man, because of the inordinate use of alcohol, morphia or cocaine, neglect his home duties, fail to keep himself neat, clean or respectable, or begin to make a foolish use of his money and nothing is done by anybody to control such a man, and in this State of New York but very little—under the existing laws—can be done to keep his family from the poorhouse, prevent his

children from becoming vagabonds or criminals or to hinder him from a slow process of committting suicide. The propriety, reasonableness and humanity of controlling habitués is not denied by anyone, and in all States of the Union the statute provides for such control as far as the property of the habitual drunkard is concerned. All the States also provide for the control of the property of those who are addicted to the use of any narcotic or stimulant.

The other side of the problem, the provision for the cure of the habit, is one recognized by three States. It is said that figures won't lie, but as a rule they are a deceit and a snare; yet, as far as it is possible to get figures to build upon, they show about sixty per cent. of habitués are curable.

For this three-fifths of a large class of sufferers this brief paper pleads. The morphine habitué, as a rule, is one whose practically incurable malady has came upon him later in life, and his usefulness, if cured, is not so apparent. The cocaine habitué is usually a young person, and while the trouble is trying and treacherous in the highest degree, many a life of usefulness follows the recovery to health.

Now what should be done? Enact a law which shall provide for the legal control of the person, as well as the property, of the habitué and thus, as a State, join the ranks of those States which have already seen the need of such legislation.

To this end the following resolution is offered:

RESOLVED. That the Homeopathic Medical Society of the State of New York hereby instruct its Bureau of Legislation to prepare and secure the passage of a law which shall provide for the legal control of the person of all those who are addicted to the use of narcotics or stimulants to an extent which renders them useless to society or leads them to waste their property.

ARE THE VIOLET RAYS A CURE FOR PARALYSIS?

W. E. MILBANK, M. D.,
ALBANY, N. Y.

I ask this question in all sincerity, because of the remarkable success attending my experiments with this apparatus.

In a discussion on this subject, Dr. F. H. Curtis, of 7 West Fifty-eighth street, New York city, advised me to try the rays as a possible cure for paralysis whenever the opportunity offered.

The first time I had an opportunity to put the rays to a test was about four years ago. The patient was a lawyer who, although 71 years of age, led a strenuous life. When the case was reported to me, I found that he was suffering from paralysis caused by a rupture of a blood vessel of the brain.

Realizing that the case was a grave one, I decided to take heroic measures to bring about a cure. Knowing that the violet rays would dissipate inflammation I evolved the theory that it might also dissolve congested blood in the brain.

Acting on this theory, I applied the rays to the patient's scalp and it soon reached the seat of the disease. At first he was unable to stand the pain, so I had to apply it very cautiously. On the second treatment, however, the action of the current gave him less uneasiness. This case was cured in 36 hours, the patient being able to talk, move his arms and legs, and act the same as before the attack. In a week's time he was completely cured and able to resume his practice.

There was a second and third attack. The second attack required a week's treatment, at the end of which he was able to dictate letters and transact business as usual.

The third attack was more severe than the two former, and called for two weeks' treatment. But the disease rapidly responded to the cure. All these ruptures, by the way, occurred along the same line of blood vessels, about one inch to one and one-half inches apart.

After the third attack I insisted upon the patient giving up active practice, and at last he took my advice. During the following summer I received two letters from the patient's wife, saying that he was devoting his whole attention to his garden and lawn, and had foresworn business. He was then enjoying better health than he had in years.

Since then I have treated three cases successfully—two of my former patients now walking the streets of Albany apparently as well as ever.

The results of my experiments are simply given for your information.

REPORT

OF THE

BUREAU OF SURGERY.

"Operations in Two Stages," - - - - - - - WILLIAM H. BISHOP.
"The Diaphragm as a Barrier to Infection," - - - J. HERBERT IRISH.
"Diagnosis of Appendicitis by Exclusion," - - - ORANDO S. RITCH.
"Thyroidectomy," - - - - - - - - - DEWITT G. WILCOX.
"Shock and its Treatment," - - - - - - - W. LOUIS HARTMAN.

OPERATION IN TWO STAGES.

WILLIAM H. BISHOP, M. D.,
NEW YORK CITY.

The object of this paper is to enumerate the several advantages of performing certain operations in two stages, rather than to advocate the method as a hard and fast rule under all conditions.

The plan often works to great advantage to the patient where a short period of anæsthesia is desirable; in abdominal operations where it is always vital to the patient that a perfect technique be preserved; in osteo-plastic resections of the skull.

Prolonged periods of anæsthesia are undesirable to all patients, and are positively harmful to some; therefore, it is easy to understand why operations in two stages should be frequently performed. Either through lack of forethought or undue zeal on the operator's part, the possibilities which this method possesses are many times not considered.

The operation for evacuation of an abscess of the liver when done in two stages, insures absolute safety to the patient, subjects him to short periods of anæsthesia, and I believe the adhesions resulting from the first stage of the operation offer greater security from infection of the abdominal cavity than can be obtained from gauze-packing, where the operation is completed at one time. It is not intended that this method should be a cloak for the inexperienced operator, or him who has not the ability and confidence which will make it possible to protect the abdominal cavity by gauze-packing, when treating pus conditions. I am perfectly aware that it is possible under any and all circumstances to adequately protect a patient against infection of nearby structures, when operating

infected regions, and I also know that such efforts made in introducing gauze packs lengthen operations, and that by completing the operation in one sitting, increase the shock attendant thereon.

In osteo-plastic operations on the skull, whether for exploration or removal of tumors, this method offers great safety to the patient.

In all cases the shock is less; and in tumors of the brain, where the skull and dura have been opened during the first stage, the tumors many times partly enucleate themselves during the period between the two stages.

It has been briefly stated in these remarks the object and applicability of the method, and it is the intention of the writer to relate what practical points have been brought out in a recent osteo-plastic operation for exploratory purposes on the brain. Neither the history of the case nor the findings at operation will be related, and I simply desire to report the conditions of the wound at the second operation, as they are of surgical interests.

The plan of every osteo-plastic operation is to raise a flap which will be composed of scalp, periosteum and bone. The object of such a bone flap is that there shall be no bony defect in the skull after the operation, and second, that by so fashioning the operation a larger area of brain may be exposed for observation. In this particular case the intention was to do the operation in one stage, but after the soft tissues had been incised in a horse-shoe shaped style, and the saw line through the bone down to the base of the bone flap had been completed, it was observed that the periosteum had been entirely stripped off from the area of bone included in the flap. As the bone area so mapped out sawed free, the base, of course, excepted, would now be deprived of nourishment immediately, if its base was fracture, the only course left was to sew up the wound and allow the soft tissues to again become reunited to the bone flap. This completed the first stage. The part then of greatest importance was what should be the length of time between the two stages.

First, how long would it take for the periosteum to become firmly reunited to the bone flap, and second, as the saw line through the bone had been made by a Gigle saw, and was therefore very thin, would bony union of the fracture take place very speedily? Naturally, it would be undesirable to be compelled to do all the first operation over at the second period.

Five weeks were allowed to pass, and at time of second operation the scalp was found very firmly attached to the bone flap, and the adhesions between the sawed surfaces were of the lightest character, and were easily broken away by a blunt instrument.

The rapidity with which fractures heal in children (and this patient was a child) certainly pointed to quite a different union of these sawed surfaces in five weeks.

In conclusion, operations in two stages are especially to be thought of in cases where very short periods of anæsthesia are

demanded, and where an unusual amount of shock is anticipated, and that the period between the two stages in all osteo-plastic resections of the skull may be lengthened to five or six weeks without any danger of union taking place between the saw surfaces.

THE DIAPHRAGM AS A BARRIER TO INFECTION.

J. HERBERT IRISH, M. D.,
SYRACUSE, N. Y.

In studying the diaphragm, one is at once impressed with its central location. It is in the very midst of the most important vital activities; respiration, circulation, digestion and excretion of urine—the most important vital processes of the body are carried on at either side. It lies in immediate contact with more important and complex organs than does probably any other anatomical entity of the body.

Its own structure is not, however, especially complex, being composed of muscular and tendinous tissues covered with serous membrane, the peritoneum underneath and pleura and pericardium above. It is muscular near the border, gradually becoming tendinous and aponeurotic at the center.

The three fovamen of the diaphragm transmit very important structures, through the lower and posterior, between the crura, pass the aorta, thoracic duct and azygos vein; one, a little anterior and to the left gives transit to the œsophagus and pneumogastric nerves, while the vena cava passes through a separate opening a little to the right.

The chief physiological function of the diaphragm is that it is the most important muscle of respiration, and, like the heart, it never rests.

Above the diaphragm lie the heart and lungs, while immediately below this thin partition are the liver, pancreas, spleen, stomach, kidneys and supra renals.

These organs are at times subjected to inflammatory conditions more or less virulent. How important a part the diaphragm plays in acting as a barrier to infection, is the object of the present brief study.

If we could imagine a human being with no diaphragm, perhaps its importance would be more manifest. Possibly a body would functionate with no diaphragm; the lungs might be filled and emptied if they lay in immediate contact with the liver, spleen, kidneys and stomach; breathing would be more labored and difficult, with possibly more atmospheric pressure to overcome, but undoubtedly we should get sufficient compensatory hypertrophy of the vari-

ous muscles of respiration to accomplish it satisfactorily. The various vital functions of digestion, respiration, circulation, etc., would be reasonably well accomplished so long as each organ remained free from disease.

All of the organs in the immediate vicinity of the diaphragm are covered to a greater or less extent by serous membrane; when a serous membrane becomes subjected to inflammation a plastic exudate is usually thrown out, very effectually fastening the serous surfaces in apposition; if the inflammatory process is sufficiently virulent to terminate in the formation of pus, the abscess is so effectively walled off at the periphery that it often breaks into some organ, or even externally, before the protective adhesions will give way.

If the parts are at rest, adhesions form more readily and are firm and strong. In diseased conditions, accompanied by inflammation of the serous membranes or organs near the diaphragm, its movements are restricted as much as possible by the patient because they are painful. If the disease is thoracic, breathing becomes abdominal to a very considerable extent, and if abdominal organs are inflamed, respiration is carried on by the chest muscles in so far as it lies in the power of the patient to do so.

Thus, the diaphragm is an important factor in limiting motion of inflamed serous surfaces. It also serves as a mechanical barrier to the extension of suppurative inflammation and extends as a wall separating the two great cavities of the body, and keeps large accumulation of pus in one from entering the other.

It is true, the diaphragm has been known to perforate, but it would seem that such cases should be few where careful methods of diagnosis are employed and appropriate treatment adopted.

Larger accumulations of pus are formed near the diaphragm than at any other portion of the body, the quantity often measurable in pints, or even quarts. These large abscesses are most frequently above the diaphragm, and are cases of empyema frequently following pneumonia. Some observers contend that they always show tubercular tendencies. These patients suffer chiefly embarrassed respiratory and cardiac action, and from the mechanical pressure of the accumulation. They also suffer from septic intoxication from absorption of the fluid. The absorption from pus accumulations above the diaphragm is accomplished chiefly by the lymphatics of the lung and plura, the diaphragm not being abundantly supplied with lymphatics on its upper surface.

The presence of an abscess beneath the diaphragm causes symptoms which are quite similar with a few added phenomena.

A subphrieme abscess also causes embarrassed respiration and circulation, not only by pressure, but also by irritation of the terminal branches of the pneumogastric and sympathetic nerves.

There is more gastric irritation because of proximity to the stomach and sympathetic irritation.

A few notes from the case record of a patient with subphrunic abscess, following appendicitis, may be of interest in this connection.

The patient, a boy sixteen years of age, first seen August 3d, had been treated some two weeks for "stomach trouble." This condition seemed alarming, and he impressed one as being decidedly septic. His temperature was 103° F., and pulse about 130°; very emaciated with a history of losing flesh and strength rapidly; he was able to take but little nourishment, both because of loss of appetite and persistent nausea and vomiting. Examination of the abdomen revealed conditions in the right iliac fossa which seemed to plainly indicate appendicitis with abscess formation. An operation was performed with as little delay as possible and a very large and hard enterolith was found immediately beneath a much thickened peritonæum; the appendix, which had perforated, lay in easy access in front of the cecum and was removed. It was very large, hard, and inflamed and with the concretion lay in a cavity well walled off below and laterally, but the upper extremity of the cavity could not be reached through the incision. No abscess could be found in that region, and the wound was partially closed with drainage.

For the next three days the patient's condition was practically unchanged, pulse and temperature remained high, nausea and vomiting were persistent and respiration from 30-35 per minute. Because of this fact, the lungs were carefully examined. The right sub-scapular region was slightly dull on percussion, to a point from the angle of the scapula to the sixth rib in the anterior axillary line. The respiratory sounds were audible, but indistinct. Frenutus was diminished.

An exploring syringe was inserted between the eighth and ninth ribs in the posterior axillary line and the syringe nearly filled with a foul-sanguino-purulent exudate; the odor was of sulphurated hydrogen.

It seemed plain that the patient was suffering from a subphremic abscess following appendicitis, especially considering the peculiar pathological condition found about the appendix four days previously.

Preparations were made for an operation the following morning. During the night the patient failed very noticeably, and it seemed as though the delay of 12 hours was a mistake, as his pulse was about 150 and very weak, and respirations between 50 and 60 per minute. In fact, the patient seemed to be in a dying condition, and any operative undertaking very hazardous.

However, the patient was taken to the operating room and a little chloroform was cautiously administered. About two inches of the ninth and tenth ribs were resected and the plural reflection on the diaphragm identified, and just below it the middle of an exploring syringe inserted, and the abscess located.

It was opened in the usual manner, and a large amount of very

offensive pus evacuated, the cavity was irrigated with hot saline, a large drainage tube inserted and sutured to the skin.

By using vigorous stimulation the patient's general condition began to improve, and in a few hours pulse and respiration were better than before operation. For about two weeks the drainage was profuse and very offensive, and at times stained with bile; nausea and vomiting ceased, and appetite improved.

The patient was discharged with the sinus healed, on September 21st.

It would seem from this case that death would have occurred before the diaphragm would have ruptured, and that death would have been caused both by absorption of septic matter and its mechanical pressure in interfering with respiration. The amount of pus and its offensive character were each remarkable. No plural accumulation that I have ever seen equalled it in quantity, or approached it in offensiveness.

As a mechanical barrier against infection, we are led to believe the diaphragm is generally efficient; its structure is strong, being muscular and tendinous, or aponeurotic, and in addition its serous membrane, when inflamed, becomes thickened and increases its mechanical efficiency. As a barrier against infection, because of its greater or less powers of lymphatic absorption, it is no more efficient than similarly constructed organs.

It is not abundantly supplied with lymphatics, and the general distribution of its vessels is such as would render absorption from its plural surface less than from the abdominal surface.

In the upper abdomen, and near the diaphragm, are abundant lymphatic vessels and glands, which fact makes septic exudates in this locality especially dangerous, the patient becoming overwhelmed by poisonous absorption. The utility of Fowler's position in actual or threatened peritonial infection is based on this principal.

Pus accumulations in this locality should be evacuated before the mechanical or absorption powers of the diaphragm are overtaxed.

REFERENCES:

Deavers Surgical Anatomy.
Kelly & Hourdon—The Vermiform Appendix and its Diseases.
Kerkes—Handbook of Physiology.
Elsberg—Annals of Surgery. Vol. XXXIV, Page 729.

DIAGNOSIS OF APPENDICITIS BY EXCLUSION.

O. S. RITCH, M. D.,
BROOKLYN, N. Y.

From the fact that appendectomies are less frequent than formerly; that acute abdominal phlegmon is more amenable to internal medicine, that we hear less of recurrent attacks, that prophylaxis is fast becoming a potent factor in diminishing the number of cases, and the differential count presenting very accurate results for the early diagnosis, for operative work it becomes us to be most accurate in our diagnosis before proceeding to operative measures. The first consideration which confronts us is, what do we find in close relation or proximity to the appendix which may become sick or diseased, and manifest symptoms that would attract attention to the ileo-cecal region; what are the differential anatomical relations as between man and woman, and what relation do they hold in case the patient is boy or girl.

If we take a section of the body bounded by a line extending from the pubes up, to and on a level with the eleventh rib, then encircle the body to a spinal column, then down the back to the sacrum and around to the starting point, we will have a space that will contain about all conditions that may stimulate appendicitis, aside from the skin, which may become erysipelatous, and the muscles from which an abscess may develop. We find the peritonæum, a portion of the bladder, part of the uterus, right fallopian tube, right ovary, broad and round ligament, deep cellular tissue, rectum ascending, and a little of the transverse colon, cecum ileum, appendix vermiformis, right ureter and kidney, lower portion of the right lobe of the liver, common bile duct, hepatic duct, cystic duct and the gall bladder, a portion of the pyloric, and the larger curve of the duodenum, right spermatic cord, lumbar and sacral plexus, with their divisions, iliac artery and veins, with branches, and a portion of the omentum.

If the patient is an adult, male, all the generative adnexa, save the spermatic cord, can be excluded at once in arriving at a diagnosis; if a female adult, we have to take into consideration every condition except the spermatic cord; in little girls, while they are endowed with the generative organs located in the same relation as her adult sister, still remaining in a quiet state leads us, in almost every case, to exclude them from consideration; while in the young boy we find the fewest obstacles to overcome, and the least amount of work by exclusion; so I would conclude that a diagnosis is more easily made in the boy, next the girl, third the man, and last and most difficult, the woman. A diagnosis can be made more easily in the unmarried than in the woman who has given birth to chil-

dren or been the victim of miscarriage or abortion; in boys and girls we are not likely to be compelled to differentiate between other than entro-colitis, acute indigestion, intestinal obstruction and peritonitis. The following diseases may simulate appendicitis at some stage of their development and progress First, entero-colitis; second, indigestion; third, acute local or diffused peritonitis; fourth, intestinal obstruction, as impaction, volvulus, imagination or intussusception; fifth, Dietle crisis, or movable kidney with or without a twisted pedicle; sixth, salpingitis, hydrosalpinx, pyosalpinx; seventh, ovaritis; eighth, ectopic gestation; ninth, tubercular peritonitis and mesenterica; tenth, acute cholecystitis; eleventh, nephritic colic; twelfth, hepatic colic; thirteenth, lead colic; fourteenth, typhoid fever; fifteenth, pelvic cellulitis; sixteenth enteralgia, and seventeenth, ovarian neuralgia.

In order to have a definite proposition before our minds, around which may scintillate various symptoms of the various diseases enumerated, let me picture a group of symptoms, with all the diseases mentioned eliminated, with no possible likelihood of their entering this picture, and then we can make a diagnosis, and the picture would be named appendicitis.

The cardinal points are first, suddenness of attack; second, pain; third, tenderness; fourth, swelling; fifth, rigidity of muscular tissue; sixth, nausea and vomiting; seventh, diarrhœa, followed by constipation; eighth, fever. The disease is ushered in suddenly, with general abdominal pain, usually diffused, more in the region of the umbilical and epigastric regions, the pain at first is severe and colicky, then sharp and aching, and finally sore and dull, the pain centralizing or locating in the right iliac region in from six to eighteen hours; the tenderness is due to hyperesthesia of the cutis and the advancing inflammatory process; the area of tenderness will be circumscribed, the swelling appears quite rapidly, and varies according to the extent of inflammation; a tumor may or may not be made out; if an abscess is present its detection would depend upon its location; the absence of a tumor is no evidence that appendicitis does not exist; in examining the swelling or tumor the percussion note is weighed according to general abdominal conditions, being either dull or tympanitic, caused by the amount of gas, fecal matter or inflammatory exudate existing; the principal object is to detect a swelling and then outline a tumor, if possible; rigidity of the lower abdominal muscles with the right rectus principally anchored, and because of its one-sided rigidity, makes this symptom a strong characteristic; localized tenderness is detected by firm, but gentle and deep pressure with limb well flexed; fever is present, and varies from 100 to 103 degrees; the pulse is full and hard in the beginning, and usually is in accord with the temperature, but later, when the disease is advanced, the normal relation of the pulse to the temperature is lost; in advanced cases the fever is not so important; the right leg is usually drawn up, there is an

anxious facial expression, the tongue is coated and moist in the beginning, then dry and dark; dorsal decubitus is the natural position a patient assumes with this disease; there is limited motion of the abdominal muscles during respiration, and when the disease is advanced, thoracic breathing is marked; nausea and vomiting are early symptoms, and are usually the result of reflex neurosis; diarrhœa is of short duration and constipation the rule; the picture having been furnished, a frame is required to complete the work, and that will be made of the blood count. Butler states that the normal count in health is about 7,000 per cubic millimeter, or an average of 1 to 70 of the red, in a study of cases by Currchman. He found in every case with a count of 20,000 and more that it proved an absolute indication of suppuration, and he considers it of more importance than the state of the pulse, temperature or palpation; and as the pus increases, the count rises. In 118 cases studied by DeCosta, he found when there was an abscess or gangrene, the count averaged 15,000 to 20,000, with an average of 17,450. A fact to bear in mind is, that in profound sepsis, leucocytosis may be absent and leucopnia present; this is because the patient is so poisoned that reaction is prevented. The results of all investigators are practically the same, which is in counts from 10,000 to 17,000; it is but a factor in the case, but from 17,000 to 25,000 it is indicative of pus, gangrene or a diffused peritonitis; this is further augmented by the differential count or the disproportion of the polynuclear cell percentage over the leucocytosis, which is usually indicative and confirming in appendicitis. These are facts, because the count lowers as soon as pus is liberated, or good drainage established. The accelerated count is not indicative of appendicitis standing alone, but is a most valuable adjunct; the positive fact is that it indicates suppuration and pus. I want to remark that because the appendix or appendicular tumor cannot be located by palpation or conjoined manipulation, it is none the less positive that the disease does not exist; it is better to locate, if possible, but its location does not bear the importance to the case as the fact that appendicitis exists. If the description I have offered makes a typical, uncomplicated case of appendicitis, we will bear it in mind and note how some other diseases compare with it.

Entero-colitis.—There is pain and tenderness over the abdomen, the pain is colicky and griping, and if localized is in the region of the umbilicus; the pain will often follow the course of the colon; diarrhœa is an early symptom, is profuse and not followed by constipation; the disease usually occurs in hot weather, and with close questioning as to the exciting cause, the condition can be determined.

Acute Indigestion.—We would be led to this condition by the knowledge of imprudence in eating and the attack closely following, but there is epigastric pain, swelling, some tenderness, but not circumscribed, a sense of weight, pain is usually dull in character,

the pain may extend along the intestinal tract and promote a diarrhœa; if vomiting is present, it is of undigested food, and the patient is relieved; the acute symptoms usually subside in less than twenty-four hours and that would clear the case of appendicitis.

Peritonitis.—Acute, local or diffused; the acute is generally primary, and may be local or general; the diffused is often secondary, but they all commence with chill followed by high fever, abdominal pain, exquisite sensitiveness; the swelling is general and is not focused; the note is tympanitic, both legs are drawn up, there is thoracic breathing almost from the beginning; a pulse of 140, respiration 30, and temperature 104 degrees with the above symptoms would be in accordance with this disease.

Intestinal Obstruction.—Unless advanced to the stage of inflammation, is unattended with fever, while appendicitis always has a rise of temperature; if from impaction, there is a history of constipation progressing to inertia of the bowels, there is abdominal pain, the percussion note is dull, a doughy, boggy mass may be outlined, especially of the colon; if the obstruction is from volvulus, it is very difficult to diagnose or differentiate; the pain comes on suddenly, the abdomen is distended, very rigid and sensitive; patient will often enter collapse in twenty-four hours if not interfered with; if there is any localization, it is likely in the region of the sigmoid or lower portion of the ileum; we can bear in mind that this condition usually occurs in persons upwards of forty years of age; if the obstruction is due to invagination it is generally found in the young; the onset is sudden, the pain is severe, with bearing-down, followed by bloody stools, and often an oblong, rounded tumor may be defined in the right iliac region.

Movable Kidney.—With or without a twisted pedicle. If we are sure there was a floating tumor before the attack, it will be of great assistance, or if the floating tumor can be defined during the attack, it may be found in the hypochondrium, umbilical or iliac region, there is no fever, pain is very severe at times; neurosis is a strong factor in the case.

Salpingitis Hydrosalpinx or Pyo-salpinx.—One must delve closely and deep into the examination; in salpingitis the disease is ushered in with rigors, fever and severe pain in one or both lateral pelvic regions; there is great tenderness upon pressure, conjoined manipulation will demonstrate the trouble in the tube, and we will find it, as a rule, outside the zone of McBurney's point; peritonitis may come on later by involvement and complicate the case, which would then be diffused; as to hydro or pyo-salpinx, the special point is to outline a tumor of the tube, and if that can be determined, the case will clear up.

Ovaritis.—There is a history of menstrual trouble, and is only of importance in the case when right-sided; pain is more or less severe during menstrual intermission and greatly aggravated at those times; the pain is dull, but during an acute attack, the pain radiates

in all directions, and when in the deep right ileo-cecal region, may be confounded with appendicitis.

Ectopic gestation.—There are symptoms of pregnancy by reflex; examination reveals a mass to the side of the uterus, and only in right-sided gestation, before or following rupture, are we concerned at this time; should there be any doubt, it will soon clear up by collapse of the patient, unless radical measures are immediately resorted to.

Tubercular mesenterica.—Is a gradual process; no tumor is detected, and only when the disease is located in the right iliac region, would it be thought of in connection with appendiceal metamorphosis. The pain is of a boring kind, but the family history and close observation, and the fact that the disease is protracted, would clear up the case.

Acute cholecystitis.—When the gall bladder is distended and inflamed, there is pain, tenderness, tumor and fever; it is the radiation of pain which may throw doubt in the case, but if the tumor is located, it is found too high for the most distorted appendix to be located in that section.

Nephritic colic.—The pain, which is severe, extends toward the groin, and may follow the tract of the spermatic cord down into the testicle; the pivotal site of tenderness and sensitiveness is usually in the region of the kidney, although it may be low down in front and apparently following the course of the ureter; this condition brings in a portion of the bladder, as it becomes irritable; dysuria, with tenesmus, is present, and this line of symptoms would lead us in the right direction.

Hepatic colic.—In severe cases the pain will extend low down as well as high up, but the center of pain is in the region of the gall bladder; pain is associated with violent cascading, but only in extreme cases will the pain radiate to the circle of McBurney.

Abscess of the liver.—Is only interesting here when the progress of the abscess has remained undetected, for then it may have burrowed well to the umbilicus, the same as in subphrenic, which may burrow deep in the pelvis.

Typhoid fever.—The onset certainly is not so abrupt as appendicitis, but there may be an even and continued fever in the beginning, right iliac tenderness, gurgling and tumefaction due to the swollen and inflamed ileum; but the patient is in a low state (physical), and it may not be easy at first to determine just the condition. If in further doubt, employ the Widal test or blood count.

Pelvic cellulitis.—Reminds me of malaria, in that so many symptoms are produced; that a multitude of sins may be covered up, this is an inflammation of the adipose and aveolar tissue, which surrounds the uterus on all sides, and extending up through and between the layers of serous membranes which form the generative ligaments; the principle symptoms are chill, fever, pain, irritable bladder, and some metrorrhagia; if the cellulitis is right-sided and

acute, the most painstaking efforts are required; a most thorough physical examination and close application to the full history will be required to clear up the case.

Enteralgia.—Has severe pain, local or diffused, comes on suddenly; is often located in the right iliac region, but the absence of colicky pain, which is often symptomatic of abdominal inflammation; the fact that pain is relieved by pressure, the loss of fever, sudden termination of the pain, and if associated as a reflex neurosis, will be sufficient to clear up any doubt.

Lead colic.—There is a characteristic history to the case; there is severe colic over the entire abdomen, but the abdomen is contracted; the pain appears to center near the umbilicus, there is no fever, often sub-normal, and if the patient is not soon relieved, convulsions, epilepsy and delirium would develop, and these would clear the case.

Ovarian neuralgia.—May be associated with dysmenorrhœa; the condition is symptomatic, rather than a manifestation of a special pathological condition; its association with a nervous temperament, anæmia chlorosis, and a rheumatoid diathesis, conditions which precipitate and augment neuralgia, its own peculiar periodicity, would be the means of clearing the case, even though that trouble might be right-sided.

If we bear in mind the picture called appendicitis, irrespective of whether it be neuralgic, congestive, inflammatory, fulminating or even the location of the appendix confirmed as against, thus we bring before our minds the leading symptoms of the various diseases as they may simulate appendicitis at one stage or another of their progress; we make a diagnosis, always bearing in mind there are typical uncomplicated cases in which no question would arise for differentiation.

DISCUSSION.

HENRY O. ROCKEFELLER: In commenting upon this subject which the writer has so masterly presented, I wish to emphasize a few points which may be of interest to you.

The temperature of appendicitis, which increases gradually until it reaches 103 or 140°, is greater in the morning than the evening before; and while the temperature increases, the accompanying symptoms increase and the tumor often becomes well defined.

In typhlitis, the temperature quickly rises to 100 or 101, is steady, or remains about the same, and there is relief of all the symptoms by the application of a high rectal enema and the temperature gradually returns to normal.

In typhoid fever the temperature is less in the morning than the evening before.

Allow me to present two cases that I believe will well illustrate the diagnosis between appendicitis and typhlitis.

The first case is of a boy twelve years of age, who ate some choke cherries on Monday, August 16, 1897. Had loose movements of the bowels on Tuesday, but on Wednesday his bowels did not move and his temperature was 99 4-5 degrees and he complained of pain in the abdomen.

On Thursday morning his temperature was 100 3-5 degrees, pain was more in the right iliac fossa, nausea, and the bowels moved by an enema, but it did not seem to give any relief.

Thursday evening his temperature was 101 2-5 degrees, vomiting, seemed inclined to raise the right knee and there was increased tenderness in the right iliac fossa.

Friday morning his temperature was 103 degrees, pain intense on pressure in the right iliac fossa, tumor easily detected. He kept the right leg flexed—some tympanitis. Called a surgeon in consultation, who decided that he should be removed to a hospital and undergo an operation for the removal of the appendix. He was therefore removed to a hospital that day and operated on the next day (Saturday).

It was found that the appendix was greatly thickened and elongated and that a rupture had occurred and a cherry pit had escaped. Upon opening the appendix (after its removal) three more cherry pits were found within its cavity. Inflammation had extended to other parts and adhesions were developed. Although the operation was performed as nicely and carefully as any operation I have seen for appendicitis, still the patient died on the following Monday.

The second case—Typhlitis. I was called to see a lady, aged twenty-two, early one morning a few years ago, who had been seen by an allopathic physician the afternoon of the previous day and had been told by him that she had appendicitis and if she was not better by morning she would have to be taken to a hospital and have the appendix removed. Was informed that she had fainted as a result of the severe pain she had when they came for me, and when I entered the room she was crying with the pain. Upon examination I found that she had intense pain in the right iliac fossa, had vomited, and upon taking her temperature found that it was only 100 2-5 degrees ; the bowels were distended with flatus. I gave her two high rectal enemas and was pleased to see relief obtained, and the expression of gladness of the mother and daughter.

The result of the two enemas was that she passed much flatus and faceal matter. The temperature and symptom slowly subsided during the next five days, and at the end of a week I pronounced her cured.

THYROIDECTOMY.

DEWITT G. WILCOX, M. D.,
BUFFALO, N. Y.

In 1850 there was a record of seventy thyroidectomies for ordinary goiter, of which there was a mortality of 40 per cent. In a record of 400 operations of similar character, made between 1850 and 1883, the mortality fell to 15 per cent., and since 1883, the mortality has been reduced to 3 per cent.

Kocher, of Berne, who stands foremost in the world as the expert thyroidectionist, has the remarkably low mortality of .4 per cent. in simple cases. Perhaps in no one field of surgery has there been a more remarkable showing in the reduction of mortality. Ten, yes, even five years ago, the ablest surgeons were not hunting anxiously for thyroid glands to remove, and when one did present itself the surgeon was rather loath to advise operation, and only did so as a last resort, after all other known methods of cure had been exhausted and there was an imperative necessity for operative relief.

This ductless gland (the thyroid) has ever been an object of study, supposition and uncertainty. That we understand its function much better to-day than formerly there is no doubt, but there is much yet to be learned.

A few words regarding the anatomy of the gland will better enable us to know how surgical measures can be applied.

Anatomy.—(As given by Mayo)—The thyroid body is somewhat like a horseshoe in shape, and rests on the trachea, with one lobe on each side, connected below by the isthmus, which crosses the upper tracheal ring. These lobes are about two inches long, being smaller at the upper hole. The right one is usually the larger, and the entire weight is from one to one and one-half ounces. The gland is invested by a thin fibrous capsule, which divides posteriorly a portion lining the posterior and inner surface, while a part passes to the opposite side behind the esophagus. This investment explains the production of pressure from tumor growths on both of these structures and the occasional appearance of tumors between them. Fibrous bands also unite the gland to the trachea, which cause the thyroid to move with it.

The blood supply of the thyroid, considering its size, is remarkable for its extent and also for the freedom of anastomosis. The superior thyroid artery from the external carotid supplies the upper pole on its inner side, dividing and entering the capsule. The inferior thyroid from the thyroid axis enters the capsule below at the hilus. The main veins are the superior, middle and inferior, although many others seem to develop in diseased organs. The

nerve supply is from the sympathetic. In intimate relation with the right inferior thyroid artery is the recurrent laryngeal nerve, which lies in the space between the trachea and the esophagus, and it is so often affected by pressure of tumors, by operation or scar tissue as to cause hoarseness.

It is a generally accepted fact that the arrest of secretion of this gland in growing children is a large causative factor of cretinism, and the entire destruction of the gland in such persons may result in complete idiocy. In adults this loss of function is borne with less serious consequences, although in the majority of instances myxedema results. The older the patient, however, the less serious results obtain.

It is well known that the thyroid gland increases in size during pregnancy, and Lange has pointed out the interesting fact that in those women wherein the gland did not enlarge, there was an increased tendency to albuminuria. Tetany also is not an infrequent result, following total destruction of the thyroid.

Billroth reports fifty-two cases of tetanus, following total extirpation of the thyroid. Many and peculiar as are the abnormal conditions which follow a lack of secretion of this gland, there is an equal number of interesting conditions following an over secretion of an abnormal secretion.

The best evidence of this over secretion is the disease known as Grave's Disease or Exophthalmic Goiter, or a better term, Hyperthyroidism. The few facts which we do know regarding this ductless gland induce us to believe that it manufactures a fluid within itself, which it imparts to the blood current as the latter passes through the gland; this substance, while it is extremely minute in the normal subject, yet is sufficient to keep that perfect equilibrium in the composition of the blood, which enables the latter to nourish nerve and brain cells in proportion to the demand made upon them for action. Moreover, this secretion seems in a measure to act as an antidote to the over secretion of other glands, like the super-renal capsules; for it has been noted that Addison's Disease, which is simply an over-activity of the super-renal capsules, is one of the consequences of a destruction of the thyroid gland.

In speaking of enlarged thyroids, I will make a distinction between such and Grave's Disease, for the latter condition may result without any enlargement whatever, merely from an over secretion of the gland.

Bronchocele or hypertrophy of the thyroid may result from a simple multiplication of the gland cells or from an infiltration of gland cells with serum, producing a cyst. It may therefore become an adenoma, colloid or cyst. In certain localities of Europe so large a number of people have bronchocele that it is regarded epidemic. While it is more or less prevalent in the United States, yet it is not regarded as epidemic.

In the majority of cases a simple enlargement of this gland, with-

out over-secretion, causes comparatively little annoyance; but there are a goodly number, and some authorities say this number is constantly on the increase, where the gland has reached such size as to become a menace to the patient's life, to say nothing of the burden of so unsightly a growth. The danger from such enlargement is pressure on the trachea, pressure on the recurrent laryngeal nerve, pressure upon return blood vessels, and the ever-present danger that the growth will become malignant. When the disease has reached such proportions then it becomes a surgical case, and must be dealt with after the manner of all dangerous growths.

As stated in my opening remarks, the operation of thyroidectomy had, until very recently, such a tremendously high mortality attending it that few surgeons were brave enough to attempt its removal. Hemorrhage, shock and myxedema seemed to stand as gaunt specters, ever ready to seize the unfortunate victim, either while yet upon the operating table or after his apparent recovery. Not until Kocher blazed the way, and traversed and retraversed the trail, did the surgeons feel warranted in attempting the operation as a routine procedure. With the low mortality, .4 per cent., which he has obtained, and his full published reports, setting forth so graphically his methods, the operation of thyroidectomy is now regarded as a practical, safe and a warrantable operation in the hands of experienced men. Indeed, it may be said that no one need further suffer from this disease any more than need a patient suffer from a uterine fibroid or cystic ovary.

About five years ago I made my first thyroidectomy. The patient was past middle life and suffering greatly from pressure symptoms. I undertook it more as a last resort. It was a cystic gland and peeled out easily from its capsule, with but little hemorrhage. I removed but one lobe, leaving the isthmus and the other lobe to functionate. She made a good recovery and I attempted others

Last winter a German woman came to me with a large thyroid, the bulk of which lay directly over the trachea in the median line. She showed evidence of pressure upon the recurrent laryngeal nerve, as she was constantly hoarse and had difficulty at times in making her voice heard. Her breathing was so impaired that one could hear her labored respirations some twenty feet distant. In her case I found the right lobe lying and pressing directly upon the isthmus. This was a colloid in character, and I enucleated the enlarged lobe. She also made an ideal recovery.

While I have confined myself entirely to a consideration of the simply enlarged thyroid, yet other operators, particularly the Mayos, are having equally good results in operations for exophthalmic goiter; and while the operation itself is no more difficult, yet heretofore we have been lead to believe that the removal of a portion of the gland in this disease was of no avail. But from the large list of published cases, which C. H. Mayo presents, we must count partial thyroidectomy as a practical and successful procedure for Grave's Disease.

One of the most gratifying operations which I have performed in the past year was a thyroidectomy. It was gratifying in the sense that directly through the medium of surgery, a woman, valuable to society and her home, was transformed from an unsightly, suffering, despondent and helpless invalid to a handsome, happy and healthful person, and I doubt if anything brings greater or more lasting pleasure to the physician and surgeon than just such transformations. Such successes offset on the credit side of a professional life a long list of the failure and disappointments on the debit side.

This patient was the mother of three children and had reached her fiftieth year. Her health, aside from the goiter, had been excellent. She was educated, refined, and would have been handsome were it not for this deformity. The gland began to enlarge when she was twelve years old. At the time of her operation the circumference of her neck was twenty-three inches. The left lobe stood out so prominently that she was an object of curiosity to all who saw her. In front the chin and sternum were on a straight line. The right side was also prominent but not as marked as the left; her breathing was labored, her voice hoarse, and she had not been able to lie recumbent for twelve years. But aside from her physical suffering her mental disturbance was ever becoming an object of curiosity. Many times, she told me, had she left the street car or a public gathering because she could not longer endure the gaze of the curious. In her desire to be freed from this burden she had tried nearly every treatment known to medicine and quackery. Iodine, (internal and local); oyster shell and various other calcarious substances; thyroid extract, spongia, massage, osteopathy, snake charming, incantations, etc., too numerous to mention. While I had known the woman well for many years, yet I had studiously avoided advising an operation, simply because I feared the danger of it, but after the success with my half dozen cases and no deaths I told her I was ready to undertake it if she was ready to assume the risk. This she quickly consented to do; in fact, was rather more eager for the ordeal than I was. An examination of her heart showed a slight valvular leak, but aside from that defect she was in very fair health. The operation was performed November 15, 1906.

Operation.—Incision extended from outer border of sterno-mastoid muscle (Kocher incision) curving downward across the isthmus to about two inches on the right side. Superficial blood vessels controlled before incising the platysma. This latter muscle (much thinned) was incised and the sterno-mastoid muscle exposed and retracted. Sterno-thyroid muscle incised, exposing capsule of the left lobe of the gland. This extended over the median line on the right side, obscuring the isthmus entirely. The capsule was incised over the most prominent part of the tumor and same peeled off from the gland. This separation was easily effected over the anterior and superior surfaces. Posteriorly it was more closely adherent and the blood supply more abundant. It was now apparent that the tumor was an adenoma of the thyroid gland,

imbedded in the capsule of said gland. It was removed entire without any amount of hemorrhage, simply ligating superior and inferior thyroid arteries. After the removal of the tumor the isthmus came into view, showing an adenoma attached to that also, about the size of an English walnut. This was carefully separated from the isthmus, as the blood supply was abundant.

The enlargement on right side of neck, which appeared before operation, disappeared entirely after the removal of the left lobe, showing that this latter enlargement crowded over on the right side and caused a swelling to appear there. The right lobe of the gland was not enlarged and was not removed. All blood vessels were ligated, wound dried, drained with catgut and closed by subcutaneous sutures. The external jugular vein was not severed. Duration of operation fifty-five minutes. Anæsthetic—nitrous oxide followed by ether. Patient took same well; had but two slight vomiting spells following operation.

The magnificent work done by Kocher and the Mayos demonstrates another triumph for surgery over a pathological condition, which until very recently was regarded as practically incurable, and the time is almost at hand when we can say that those distressing conditions resulting from exophthalmic goiter, which do not yield to remedies, can be conquered safely and effectually by the surgeon's knife.

SHOCK AND ITS TREATMENT.

W. LOUIS HARTMAN, M. D.,
SYRACUSE, N. Y.

Shock. This subject is of interest to all, not only the surgeon, but the general practitioner, as upon meeting this condition we must be able to cope with it instantly when it appears to us.

I will take this subject up from two points, as there are two phases of the same, one being psychic or mental and the other nervous or physical. We may have it singly or in combination.

Fear or psychic shock to my mind is of a more profound condition and proves of more serious nature than physical, as the latter is more amenable to treatment than the former.

I had an experience not long since when a patient succumbed to psychic shock. She stood in such fear of the operation from the time it was first announced that she could scarcely contain herself, at the same time she consented willingly, as she was aware it was her only hope for a recovery. Her heart, lungs and kidneys; in fact, her whole condition, with the exception of her mental, which was from fear only, was good. The operation was not severe, a hys-

terectomy, which was of short duration and very little loss of blood. There was not the usual perspiration we have from physical shock, but other symptoms existed, and with all the force and knowledge at my command treatment was administered without staying the progress and death came.

The question arises, do we gain anything by keeping a patient in preparation at his home or in the hospital for a time before an operation? Emphatically no, because the mental shock far overbalances any physical strength we may even hope to gain.

As to treatment of shock, this should be commenced even before the operation is started by relieving the patient of fear, not giving her any more time to think of same than it is possible. The operation should be done as expeditiously as it is consistent for thorough completion of same in order to save a long anaesthesia. Second, the smallest amount of blood possible should be lost, impingment of nerves avoided as much as possible, temperature of room and covering of patient well looked after.

When sudden shock comes on during the operation Adrenalin Chloride is far superior to Strychnine, and small doses oft repeated is better than a large amount at one time. Hot saline intravenous at a temperature of 120; this temperature will do no harm as you may go up from 156 and 160 before blood albumen will coagulate. When you have the abdomen open the best way is to fill the same and continue the irrigation unless you are ready to close. It is always well and good practice to fill the abdomen with hot saline if you do not have shock at the time, as it will prevent secondary, also relieve the thirst. The old saying is, the first blow is half the fight, therefore strike the first blow by prevention so as not to allow shock a chance.

The question of intravenous saline, if you do not obtain the desired results by the first operation it should be repeated; as to strychnine, I do not value it as highly as I might in this condition.

When profound shock appears and we do not get the desired results from intravenous saline the following should be administered by rectum, strong black coffee ziv, whisky zii given high; continuous high rectal irrigation of saline is of great benefit also. The bed should be well looked after, have plenty of hot water bottles or cans filled with hot water placed in the bed some time before the patient is placed therein, and see that they are not so hot as to burn the patient. In shock, a severe burn can be obtained without much trouble.

Long anaesthesia I believe is productive of greater physical shock than the operation of itself in many instances.

DISCUSSION.

DR. HARTMAN commented as follows in the course of his paper: "Speaking of psychic shock, I believe that to-day we have more

trouble from psychic shock, from mental depression before the operation, than we do really from the operation itself. That has been my observation in the last two years.

"My observation has been that where we have a patient suffering from psychic shock we do not get the perspiration that we do from physical shock, but, aside from that, the other conditions are practically the same. I believe we find more depression of the heart than anything else.

"Another point I wish to make, I do not believe we gain anything; in fact, I believe we lose, where we put the patient in preparation for any length of time where he knows that there is an ordeal of that sort pending.

"I believe we are all prone to use a hot saline—a saline not hot enough. I think we are prone to use it at too cold a temperature, fearing a coagulation of the blood albumen; but when you come to consider that we can go up to a high temperature, that the blood album does not coagulate until about—some physiologists give 158 and others 160—we can go quite a ways beyond 120.

"That is, when you complete your operation, I think it is a great deal better to fill the abdomen full in all cases, whether you think the patient is suffering from shock or not. I believe it is better to leave it full. It certainly does no harm.

"You have all as surgeons seen slight operations followed by a terrible shock, where it was necessary to have a prolonged anesthesia and the operation itself very simple, and still the patient suffer considerable shock."

J. B. GARRISON: I would like to ask if in this condition of psychic shock, the purely mental condition, as it seems to be, the best way of preparing them, or the best way of offsetting that shock, would not be the use of the true homeopathic remedy.

GEORGE A. SHEPARD: Dr. Hartman made the statement, which I have often heard before, that there is danger in prolonged anesthesia. In mastoid work it is necessary frequently to keep the patient under the anesthetic for a long time. I have seen a patient under anesthetic for from an hour and a half to two hours and a half, and it is often necessary because it is a tedious operation. Now I have seen very few cases of shock, any serious shock, after that. I have failed to see many cases that have seemed to suffer seriously from the anesthetic, given properly, for a long time, and, although I have not had much experience in general surgery, I question whether that statement is as true as most people think it is. I have seen a good many cases under anesthetic for a very long time, and in mastoid operations I have seen very few cases of shock, and those that I have seen have been in most cases where there has been a very short operation, which has been after a sudden injury, or where there has been no previous dread of the operation, too.

DEWITT G. WILCOX: I should say in answer to Dr. Shepard's inquiry, that the question of shock, relative to the length of time during which the anesthetic is given, depends very much upon the

nature of the operation. You can spend from an hour to two hours and a half on a mammary amputation, where you are taking out the axillary glands, and have your patient show very little shock indeed. You can spend from forty to sixty minutes on an abdominal section and have your patient show a great deal more shock. I think that the shock is increased in proportion to the magnitude of the operation, especially when the abdominal cavity is opened. We always get more shock there with the same relative anesthesia than we do elsewhere. So I should say that that would answer the doctor's question very decidedly indeed, that it would depend on whether or not any important cavity were opened.

As to the method of overcoming shock, or combatting it, by filling the abdomen with saline solution, I am inclined to question the benefit of that. Five or six years ago I thought it was a good thing, and in nearly every case I sent the patient from the table with the abdomen filled with the saline solution. But I didn't find they did well, and I have abandoned it altogether, and find that my patients make very much more prompt recovery, and do not have any more shock by leaving the abdomen perfectly dry, and, in fact, making an extra effort to keep it dry, such as having the sponge dry and allowing no fluid whatever into the cavity.

Then, as to combating shock by saline enemas, I think the method that Murphy, of Chicago, has inaugurated, of allowing the saline solution to trickle into the rectum slowly for an hour or two, to absorb a pint, or a quart, is very excellent, indeed. Just as soon as the patient is placed in bed, have a douche bag filled with the saline by the side of the bed, perhaps three or four inches above the level of the patient's body at the rectum, and then with a nozzle introduced, allow the fluid to trickle there for an hour and a half or more, just about as fast as it will be absorbed. I find that will overcome shock quite as well as to attempt to fill the rectum full, and that can be kept up sometimes for 24 or 48 hours, allowing it to trickle in in that way, where shock is likely to last any great length of time. If the shock is profound, and you must have immediate action, then the sub-cutaneous or intravenous method is decidedly better; but I do not think you get very good results by filling the abdomen with fluid.

G. W. ROBERTS: I would like to ask Dr. Hartman, regarding these cases of psychic shock, how long after the operation does the patient die?

DR. HARTMAN: Died about three days after the operation.

DR. ROBERTS: And with what symptoms?

DR. HARTMAN: Simply clear-cut symptoms of shock, nothing else.

DR. ROBERTS: You mean by that, low pulse, vomiting, etc.?

DR. HARTMAN: Yes.

DR. ROBERTS: Abdomen swollen much?

DR. HARTMAN: No, sir; not a particle.

DR. ROBERTS: Well, a shock which lasts for a few days, of course, is rather an unusual form; I am not familiar with it. Psychic shock I never did have very much confidence in. I do not know that I have ever seen a patient so frightened that I thought it had any very great bearing on her standing the operation. As soon as the patient was under the anæsthetic all effect of that disappeared. To my mind, the great points relating to the question of shock are the points of prevention of shock. One of these that I hold to be most important is the preparation of the patient, thorough preparation of the field of operation before the patient has come on the operating table. I disapprove very strongly of the methods which expose the patient for some moments when she is under the anæsthetic, or going under the anæsthetic, and which wet the patient previous to the time when the operation begins. It is absolutely impossible to control this fluid, and usually it strikes the clothing, the towels, the patient's nightdress, whatever she has on on the operating table—they become wet, and a process of evaporation goes on which abstracts the heat from the patient very continuously and fairly rapidly throughout the operation.

Speaking of the effect of abdominal operations, I thoroughly believe with Dr. Wilcox that we do get more shock in those cases; but we only get more shock in case we actually expose a large surface of the abdomen. If, in making a free incision of the abdomen, we wall off that portion of the abdominal cavity which is not being operated on, so that the air does not come in contact with it, and so that evaporation does not take place on that surface, and if we refrain from pulling strongly upon the orifice—for instance, pulling upon the mesentery will produce a rapid and very sudden shock; if we refrain from doing those things, and from handling the tissues with great traumatism, great lack of care, we usually succeed in getting along without shock.

I agree with Dr. Wilcox also regarding the use of solutions in the abdomen. As he says, some five or six years ago it was my custom, following very largely the reports of the work of Dr. Clark, of Baltimore, to fill the abdomen with a saline solution. Now, I have absolutely no use for irrigation under any circumstances. I can scarcely think of circumstances under which I use an irrigator to remove fluid in the abdominal cavity. The technique is strictly a dry one. Even the sponges are not moistened. The abdomen, in the first place, is not moistened, and if we meet with pus it is perfectly dry, and I find my cases do immensely better. I think I can honestly say—and I must say, before stating this, that I have very little emergency surgery; I do not see the cases of crushing injuries and things of that sort—but in abdominal operations I do not recall a marked case of shock for the last four or five years. I think it is avoided by the use of the catheter in the first place, not wetting them, and abstracting the heat by evaporation, giving the anæsthetic for as short a time as is consistent with good, fair work,

trying to keep the abdomen protected from the air, refraining from great traumatism to the tissues.

But this question of psychic shock, which ends in three days in the death of the patient, is a new one to me, and I am very glad to have heard about it.

DR. HARTMAN: Of course, I may not be able to recognize shock myself, but I thought I could. I had three other men see this case; they were good men, and all of them could diagnose the case as one of shock. Nothing else seemed to be apparent to kill the patient. It is not the first time I have seen psychic shock, and I heard a very able man, Dr. Gramm Hammond, of New York, talk on the question of psychic shock not long ago, and he impressed me with things that I had never been impressed with before. To me he put an entirely different light on the question of shock, and I have noticed since then, and looked back upon cases I have had heretofore, and can see wherein psychic shock has been a great detriment and has cost the life of patients. In the case of this patient I speak of, there was no organ but that was normal. The heart was in normal condition. There was nothing but depression, and which was mental, that caused the death of this patient.

As far as filling the abdomen with fluid is concerned, I am not accustomed to have very much shock from abdominal operations, but it is more in emergency surgery that you will get shock, in crushing injuries, and things of that sort; and I have found that where you have profound shock with crushes, and where you have to open the abdomen, that leaving the abdomen full of hot solution, not warm, but hot solution, is very beneficial. Dr. Wilcox speaks of Dr. Murphy's keeping a hot water bag up there. If you could keep your water at a temperature of 120 in your douche bag, trickling down there, I think it would be a good thing; but it is impossible to do that; and I think, in that case, if you run cold water in there, it is going to do more damage than good. I believe in that theory, however.

DR. WILCOX: I do not say in the abdomen; I mean in the rectum.

DR. HARTMAN: I say, in the rectum. And regarding anæsthesias, I am simply drawing from my own experience as to long anæsthesias, from the observations I have made. In minor operations, where they have taken a long time, I have seen patients suffer severe shock, and the operation have nothing vital about it at all which would produce shock. We have all seen that in great healthy fellows that have been under a prolonged anæsthesia and have had a slight operation, and yet have suffered profound shock from it; and it was not due to the operation.

REPORT

OF THE

BUREAU OF GYNÆCOLOGY.

"The Backache of Endocervicitis and its Cure by Operation," - - - - - - - - - - HOMER I. OSTROM.
"The Results of Ventro-Suspension," - - - - H. R. GRANT.
"The Results of some Uterine Infections," - - - WM. FRANCIS HONAN.

THE BACKACHE OF ENDOCERVICITIS, AND ITS TREATMENT BY OPERATION.

HOMER I. OSTROM, M. D.,
NEW YORK CITY.

The close clinical relation between certain forms of backache and certain disases states of the cervical endometrium, is a matter of daily observation, and this connection between a symptom—for backache is nothing more—and a well-defined local condition, is seen to be one of effect and cause, as we study the pathology of the lower segment of the uterus, and regard the anatomical structures with which it lies in contact.

The backache that I have learned to associate with diseases of the cervical endometrium, is a dull, persistent aching in the region of the promontory of the sacrum. The pain-spot may be covered by the palm of the hand; it does not change its location; is greatly aggravated by standing; walking sometimes affords relief, and by any conditions that induce pelvic congestion, or engorgement of the uterus, as menstruation, or excessive coitus, the latter concerning especially the lower segment of the uterus, which, because of its erectile tissue, is contributary to the erethism of the sexual act. With this backache there is almost always constipation, which in many instances has been brought about by the patient's dread of the pain that attends defecation. Emptying the rectum, for there the suffering is located, is delayed, or performed at irregular intervals, until the whole intestinal canal becomes torpid, and the bowels act only when mechanically stimulated to do so.

Such a clinical picture always suggests to me the lower segment of the uterus as the cause of the backache, and when presented, I have no hesitation in referring the seat of the disease to that part

of the reproductive organs; and upon an examination I am not disappointed in finding the following conditions:

There is a cervical catarrh; sometimes this is mixed with a vaginal discharge, but generally the leucorrhœa is of that glairy, transparent character, non-sanguineous unless there is glandular hyperplasia, and erosion of the cervix; that indicates undue secretion of the cervical glands alone.

Digital examination shows the cervix large, and soft, its contour depending upon the paraty of the patient; for this cervical disease is not confined to those who have borne children. In addition, the uterus is frequently acutely anteflexed.

More important than the feeling of the uterus is the condition of the utero sacral ligaments. In a healthy pelvis these organs are usually not readily felt unless the uterus is raised, or the cervix is forced forwards. But with the endocervicitis that induces backache, the utero sacral ligaments appear as tense cords extending from the sides of the lower segment of the uterus, to the sacrum. The ligaments are very sensitive, pressure upon them increasing the pain in the back.

Let us pause for a moment, to consider the physiology of these ligaments; for, as on a former occasion ("The Utero Sacral Ligaments and Their Place in Pelvic Pathology, *American Journal of Homeopathy*, March 1906) I have said, I look upon them as most important factors in many gynecic diseases. They are certainly inseparably associated with the causative relation between diseases of the endometrium and a certain form of backache.

We will note that the lower segment of the uterus, compared with the fundus, is immovable, and this fixed position is in a great measure due to the utero sacral ligaments. They not only hold the uterus up, but are instrumental in maintaining the relation of the portio to the upper part of the vaginal tube; a position that I believe has to do with the ability of the sperm cells to enter the cervical canal.

The utero sacral ligaments contain some non-striped muscular fibres—*muscularis retractor uteri (Luschka)*—which are continuous with the musculature of the uterus. These functionate in slightly contracting and relaxing, to accommodate the cervix to the changing relations of the uterus to the vagina, urinary bladder, and pelvic vessels.

Still another point for consideration is the innervation of the utero sacral ligaments. This is accomplished through the inferior hypogastric nerve plexuses, the essential gynecological nerve centres. They are receiving and distributing exchanges for impulses from the spinal nerves, second and third sacral, and the sympathetic system, and through filaments communicate with all the internal and external genital organs. The nerve supply of the utero sacral ligaments is not merely a distribution of branches, but the plexuses are situated close to where the ligaments leave the

spine, and are the chief structures through which the trunks gain access to other organs, and are distributed to the pelvis. The same liberality of nerve supply is not found in the other uterine ligaments; neither the broad ligaments nor the round ligaments contain more than a few fine filaments from these plexuses.

The practical application of these anatomical and physiological data will enable us to understand the relation between diseases of the cervix and pain in the back; for it is very evident that any condition of the lower segment of the uterus, with which the utero sacral ligaments are in contact, that interferes with their action, or that induces pressure upon their nerve filaments, as infiltration or cellulitis, must make itself known by pain, not only in the ligaments themselves, and the sacral nerves, but also in remote parts with which the inferior hypogastric plexuses are connected.

Chronic inflammation of the cervical endometrium—chronic endometritis—furnishes the local structural changes that, involving the utero sacral ligaments by continuity, so interfere with their function and impinge upon nerve filaments, as to cause the backache that I have referred to as pathognomonic of this disease of the lower segment of the uterus.

I have not found that acute endometritis, unless associated with some other disease of the pelvis that centers in Douglas' cul-de-sac, is associated with this persistent backache, but chronic inflammation, which is never superficial, the disease affecting to a greater or less degree all the elements of the mucous membrane, is one with infiltration of the utero sacral ligaments, and their consequent arrest of function, and impingement upon their nerve filaments.

Our concern is here strictly confined to the direct effect of endometritis upon the utero sacral ligaments, but it may not be amiss to call attention to the results of inflammation of the cervical endometrium, upon the body of the uterus. The very definite musculature of the internal os, which is capable of undergoing considerable variation of calibre, is mechanically closed when the cervical endometrium is swollen. Drainage, therefore, a fundamental principle of gynecology, as of general surgery, is interfered with, or wholly suspended; in consequence the uterus is not emptied, and its contents, by continued accumulation, may be forced back into the Fallopian tubes, and so reach the general peritoneal cavity, inducing conditions with which we all are familiar. This differs from corporeal endometritis, in which nature opens the internal os, thus favoring drainage, and preventing infection by way of the oviducts.

Discussion of the minute pathology, or an exact analysis of the clinical phenomena of chronic endometritis, are not essential at this time; only so far as they relate to the cure of the malady are they here important.

The essential points for consideration are that we are dealing with an actual tissue change that involves all the structures of the

mucous membrane, the glands, and the musculature of the lower segment of the uterus, and that these changes spread to the utero sacral ligaments, causing in them contraction and infiltration. I believe that such conditions in any location are amenable to surgical treatment only, and that other methods involve loss of time and introduce a very potent element of uncertainty as to the results.

I therefore operate on these cases, my technique depending upon the stage at which the disease comes under my observation, and consequently the extent to which the utero sacral ligaments are implicated.

As I have before said, this condition of the lower segment of the uterus has become chronic before the peri-uterine structures are attacked; but if there is no very marked infiltration or contraction of the utero sacral ligaments, even though the characteristic backache is present—and this is quite possible—I find that by attacking and removing the cause, the diseased cervical structures, and by the subsequent judicious use of tampons, a cure may be effected without what I have elsewhere called "tenotomy of the utero sacral ligaments." Curettage of the cervical canal alone will frequently cure these cases, but the operation must be thorough, and remove all diseased tissues down to the musculature. Occulded glands will be opened, and drainage favored. Local depletion is also induced by warm Creolin douches, begun within twelve hours of the operation.

I do not pack the vagina, but as soon as the operative oozing ceases, I replace the uterus, and begin treatment with Ichthyol tampons, continuing the Creolin douches. Not only is this antiseptic, but Creolin tends to resolve cellulitis and reduce tissue infiltration. From the beginning I direct that the bladder shall be kept empty, even though the catheter is necessary for that purpose, and the nurse is instructed to free the rectum of all fecal accumulation. I also encourage the patient to lie prone on her abdomen as much as possible.

The remedy that above all others I depend upon to assist in reducing the general enlargement of the uterus and aid in its return to the normal size, is *Cinnabar*. I prefer the third dectrituration, administered three times daily. This is merely a matter of experience, but I always exhibit this remedy in these cases.

In severe cases, when the utero sacral ligaments are contracted (this is to protect an inflamed cervix—thickened, and sensitive feeling, like tense cords), curetting the cervical endometrium will not effect a cure. We must then, in addition, operate on the ligaments. The muscular spasm must be relieved by cutting the fibres and the cellulitis and induration removed by applying the same principle that underlies the treatment of similar conditions in other locations—the relief of surgical tension by drainage.

I have sometimes thought it wise to divide the technique into two stages, allowing one or two weeks to intervene between the

curetting and the tenotomy, but both operations can be done at a single sitting with good results. The curetting is the primary operation, and when immediately followed by dividing the utero sacral ligaments, I pack the cervix with iodoform gauze to guard against infection, removing the packing as a final step in the procedure.

A broad, rather long speculum allows dislocation of the uterus, and the ligaments readily come into view. By keeping the curved scissors in contact with the cervix, the ligaments can be severed without entering the peritoneal cavity, and the entire manipulation conducted extra-peritoneally. During this step, the left forefinger pressed well back into Douglas' pouch well serve as a director upon which to cut. It is not necessary to carry the incision across the posterior vaginal fornix, each ligament may be divided separately, thus minimizing the danger of entering the peritoneal cavity. The extent to which the ligaments are divided will be determined as we proceed, by testing the ease with which the uterus is replaced and brought in normal antiflexion.

After the ligaments have been divided sufficiently to relieve all tension, the technique is designed to prevent post-operative contraction and consequent defeat of the treatment. Packing will not do this, and I therefore bring down and interpose a layer of subperitoneal tissue with its peritoneum between the cut edges, and fasten it with catgut sutures to the vaginal fornix. The utero sacral ligaments are thus completely obliterated, and all possibility of reflex symptoms, from their subsequent contraction, prevented.

The post-operative treatment consists, after the first few days, during which douches are given, in using every third day an Ichthyol tampon until all sensitiveness has been overcome, and healing is completed.

Sometimes after opening the abdomen for other conditions, I have cut the uterine ligaments from above, but I do not think the results as permanent as when the tenotomy has been vaginal. The chances of contraction are greater, for there is no intra-abdominal certain method of keeping the raw surfaces apart; therefore, the condition is liable to recur, and the backache to be as severe as before, notwithstanding that the cervical endometritis has been cured.

THE RESULTS OF VENTRO-SUSPENSION.

A. R. GRANT, M. D.,
UTICA, N. Y.

The excuse for this paper is to dissipate the somewhat prevalent idea that operations for suspending or for holding the retro-placed uterus forward are many, and that no definite operation or method can be advised that promises uniform success. Lack of faith in the wisdom of such operations has heretofore been shaken because surgeon A does the "Alexander," surgeon B the "Emmet," surgeon C the "Gilliam," surgeon D the "Ferguson," surgeon E the "Kelly," and so on, each surgeon making a hobby of one and ignoring all the others. It would seem that each of these procedures was open to some objections, and none was applicable to all degrees of uterine displacement.

The various operations of shortening of the round ligaments are valuable in selected cases, where the woman is not in the child-bearing period, but they are not so universally practicable as the simple hysterorrhaphy. It is my practice to curette the uterus, repair its cervix, and re-establish the perineum before opening the abdomen, and stitching the posterior surface of the fundus to the abdominal peritoneum by two forty-day chronic gut threads. A vaginal plug of gauze completes the operation. The after-care to be regular, catheterization every five hours, and passive turning in bed only, for the first ten days. Convalescence is uneventful, the mortality in my cases being nothing. Frequent, post-operative examinations show that the uterus which is at first fixed, becomes slightly movable by the seventeenth day, and that at the end of the fourth week a ligament of one and a half to three inches has been formed from the peritoneum which holds the uterus away from the hollow of the sacrum and yet allows it motility. This I have confirmed in abdomens reopened for other causes a year after the suspending operation. The relief of symptoms of backache, dragging pains, pressure on the rectum and the nervous reflex symptoms that accompany such a pathology has been immediate and lasting. As applied to women in the child-bearing period of their lives I believe this to be the best radical operation. Its indications are confined to women during the active period of their lives.

First. Where adhesions render anterior replacement impossible.

Second. Where the uterus cannot be maintained in its anterior position by tampons, pessaries, applications and postural treatment.

Just a word in closing, in regard to prolapsus cases in older women. In such, the fundus is sutured to the recti muscles and fixation of the uterine body to the abdominal wall assured.

There has recently been introduced in this country a pessary which holds and completely relieves protrusion of the uterus bladder and rectum into the world. It bears the name of Schatz, of Vienna. I have placed a number of these pessaries in the worst of such cases where operation was refused, with the most happy effect. The instrument is saucer-shaped and is imported in three sizes by Woodward, of Middletown, Connecticut. There is no belt nor strap nor stem to irritate and annoy, and I can testify that it has held the worst cases of complete prolapse of the pelvic contents.

DISCUSSION.

DE WITT G. WILCOX: I simply want to endorse what Dr. Grant has said along this line. This is a condition which every general practitioner meets—retro displacement, prolapse of the uterus—and I think, too frequently in the mind of the general practitioner does the opinion prevail that nothing can be done except to palpate or apply a pessary support. While I would not advocate that in every case of slight displacement and procidentia, prolapse, abdominal section would be necessary; yet in those cases where ordinary measures will not relieve it to any extent, we have a handy means of complete relief through some form of suspending the uterus, especially in women who have passed the climacteric; women, particularly, who are subject to hard work, and who are rendered almost invalids because of the procidentia and prolapse of the uterus. I think in those cases the operation of suspension and fixation is ideal from the fact that it converts those same invalids to comfortable, healthy, happy women.

THE RESULTS OF SOME UTERINE INFECTIONS.

WM. FRANCIS HONAN, M. D.,
NEW YORK CITY.

The limited time for the presentation of a subject in this section of the Society prevents the possibility of anything but the most cursory consideration of the topic to which your attention is invited.

It is my purpose to speak of some of those infections which reach the uterus through the lower genital canal, and which I believe are, for the most part, entirely preventable; and it is for this reason that I tax your patience upon a rather well-worn topic.

In the light of modern pathology, inflammatory changes in the uterine mucosa are due to micro-organisms or their products, and from this infection is chiefly due all pelvic inflammation. Infection

reaches the uterus in various ways; it may come from above, from a focus like a septic appendix, from tuberculosis primarily in the intestines or oviducts, from the blood in general infectious diseases, as a metritis, seen in acute exomthemata. It is to those infections which are introduced through the lower genital canal, and which, to my mind, are due to certain preventable errors on the part of the physician and patient, that I wish to refer. (1) Those connected with labor and abortion; (2) improper operative technique or faulty and obsolete methods in the so-called local treatments. The vulva is almost a skin surface and with the lower part of the vagina is exposed to the action of myriads of micro-organisms both in health and disease; but the vagina is protected from pathogenic invasion by its acid secretion, which harbors and causes to thrive a protector in the shape of an aneorhic vaginal bacillis. Whitridge, Williams and Krönig agree that pyogenic cocci are absent in the vaginal secretions of pregnant women, therefore auto-infection is impossible, and even though occasionally bacilli may be found in the vagina, the os externum is the boundary line above which no micro-organisms exist. This is of great importance in asepsis and antisepsis in obstetric practice. Therefore, infections of the uterus under these conditions come from without. Frequent vaginal examinations and douching often do incalculable harm, and may be the means by which septic organisms are introduced. It would hardly seem necessary to dwell upon the necessity of simple aseptic cleanliness, the prompt care and repair of injuries to the maternal soft parts which prevent proper normal involution, and permit relaxation and stamp upon the pelvic and vaginal contents a pathological state sometimes fraught with grave consequences to the health and happiness of the woman. We see daily the consequences of the lack of proper precautions and after-care of puerperal patients, and the utter disregard of the attending physician to their condition at the time of their discharge from his care. It seems still that the idea is prevalent in the minds of the laity that laceration during labor is due to lack of skill on the part of the accoucheuer, and this notion is frequently fostered by some rival who proudly tells the family that he has practised his profession for forty years, and has never allowed a laceration of the perinæum. Lacerations are not preventable in even the majority of instances in which they occur, and the patient should know this in advance, and should also know that repair at the time, due to lack of vitality of the tissues or chance infection, will not accomplish all that is desired, so that a secondary operation may be necessary later; instead of which it is our common experience to find a patient who perhaps, upon entering the married state, represented a type of woman of normal health and mental vigor, capable of all that marriage means and entails as to wifehood and maternity, in time becoming a neurasthenic invalid with physical distress and mental illusions. Examination will reveal unrepaired injuries to maternal parts and

consequent infections, which in turn have left more or less permanent effects of the ensuing inflammations which have extended through the entire pelvis. What a severe indictment against the medical profession, and yet is it not a frequent occurrence to find such cases. You may remember the little handsome, bright-eyed girl you knew before marriage transformed into a haggard, pale, nervous wreck, with backache, headache, physical weakness, with mental obliquities and imaginings; surely, not much of a comfort to a husband and children, and not a credit to the care of the medical attendant. The unfortunate part of such a case is that to a large extent the cure, if not the prevention, is in the physician's hands. To speak of abortion as self-induced, or quasi-criminal, is to open up a subject too large for even the entire time of this bureau; but how often does it occur that the pregnant woman, accompanied by perhaps her husband and mother, wait upon the physician and give him endless, and to their minds, convincing arguments, as to why she should not go to full term. If she is to be taken to a specialist, the family physician is frequently added to the list, possibly armed with alleged statements from the former accoucheur that under no circumstances should this woman be allowed to give birth to another child. Such was my own experience once —the entire family, with the physician, and a statement from one of our gynecologists of international fame, as to the almost certain risk of death that labor would entail. After examination, my opinion was that there was no reason for alarm, and I prophesied a probable easy birth. Such hysterics and mad outbursts on the part of the patient, when she received my opinion, have changed my mind about maternal impressions; for the resulting child, which came even without the aid of the physician, so easy were the pains that he was not summoned in time, should have been all the stigmata of bad temper and grievous disappointment; instead of which she is a beautiful, sunny-haired little elf, the pride and joy of a family in which for years my picture was turned to the wall. The gynecologist is not importuned so much in the beginning; it is after the woman, despairing of assistance from the family physician, goes to some abortion specialist or ignorant midwife, that he is called upon to save the life of a sapremic or septic woman; it is not now a matter of future health or integrity of organs, but a question, frequently, of life or death. The woman, to rid herself of her condition, takes any means at hand to accomplish the result—drugs, insertion of foreign bodies into the uterus, from a hat pin to a knitting needle—perhaps not realizing the danger, or again in defiance of it. I refer now to the married woman who will not, as a matter of expense or convenience to herself, take upon herself the burdens of maternity. The frequency with which this crime is committed in these days is sufficient to show that civilization and higher thought, if they teach, fail to guard the sanctity of human life or respect the rights of the unborn, and that there is no power

in education, law, refinement or any other influence save possibly a deeply-rooted religious conviction to repress savage and utilitarian instincts and subordinate them to the best uses of society. The shrinking of the fashionable mother from the pain and possible loss of figure incident to child-bearing, and the selfish desire to avoid parental care and responsibilities, seem almost beyond the hope of religion. Outside of the married state, the most common cause of such wicked practices is the disgrace which attaches to such violations of chastity on the part of a woman should resulting pregnancy become known. In this country and in England, such conditions spell social ruin and a deep reprehension on the part of the community, while perhaps on the continent no great moral wave of condemnation would follow. The temporary triumph of man's ardor and temptation and a natural instinct on the part of a woman over a more or less necessary social convention. Be it as it may, the result of a desire to escape the responsibilities of the married state, or in an effort to hide a condition which brings about social ostracism, a woman puts the first question mark against her sexual health. Nature is outraged, and that kindly Old Dame forever remembers the desecration of the sanctuary wherein occurs the noblest sacrifice and the most inspiring phenomenon to the human mind. There is a reckoning time, and for the profanation of the human temple, the seat of conception, the penalty is exacted with oftentimes fearful consequences.

In well-managed maternity hospitals and in the practice of the better class of obstetricians there is a very low percentage of infections; but frequent vaginal examinations, unnecessary use of forceps, meddlesome manipulation during the second stage of labor, introduction of the hand into the uterus to detach placenta, and the routine use of douches are frequent causes of septic infection, and should be avoided. Infections following criminal or spontaneous abortions are so frequent as to be seen in the common experience of every practitioner. The practice of making applications to the endometrium at the office or the house of the patient is almost a criminal offense, dangerous alike to the life and health of the patient, and sooner or later septic infection is certain to result. Such cases, with absolute destruction of the tubes and ovaries for procreative purposes have come within my notice several times. In abortion or labor, one of two conditions may follow improper treatment—a putrid intoxication or supremia due to absorption of the results of decomposition of perhaps clots or membranes left in the uterus. There is an absorption into the blood of the alkaloid products of putrefaction, the ptomains or the toxins of certain bacteria. The lesion produced in the endometrium under these circumstances varies with the micro-organisms concerned, and still more according to their virulence. If one has to deal with putrefactive organisms to colon bacillus and ordinary pus bacilli of lesser virulence, the process remains more or less limited to the endometrium and

causes marked local lesions. If the microscopical conditions of this condition are studied, the differences between this and a virulent streptococcic condition are marked. In the putrid form, sections through the wall of the uterus will show a thick layer of necrotic material imbedded in which are large numbers of micro-organisms; beneath this a thick layer of small cells infiltration, a leucocytic wall of protection, and under this more or less normal tissue. Careful study shows the organisms limited almost entirely to the superficial necrotic layer, a few in the protective zone, and none in the tissues beneath; this is an illustration of nature's mode of preventing invasion by pathogenic bacteria. In the case of streptococcic or virulent infection, a very different condition is noted; there is also a thin layer of necrotic material containing organisms, the protective zone of leicicytes is very thin, or absent altogether, and the micro-organisms are found making their way in through the lymphatics to the peritoneal covering. In this last case, curettage is contra-indicated on account of the danger of further breaking up the zone of protection, and in the former should be done lightly for the same reason. In these infections parametritis, salpingitis, ovaritis, peritonitis, retro-peritoneal phlegmon, pyæmia, phlegmasia alba dolens, are complications which ensue with varying frequency. Thus the patient's life frequently is imperiled by what is apparently, in the beginning, a mild condition. Should the individual escape with her life, it is at the expense of damaged organs, pathological changes of more or less permanency, with the resulting reflexes to continually harass and deplete the nervous system.

The infection which probably works the greatest destruction, not to the life of the patient, necessarily, though there is a mortality, is the infection by the gonnacoccus. This infection has been the cause of much discussion as a causative factor in producing pelvic disease. Noeggenrath, Sänger, Sinclair and Tait made it a paramount issue, which has not been accepted entirely by the profession. The theory of a latent gonorrhœa producing a specific endometritis years after the original attack, is frequently seen, but it is often impossible, in chronic tubal diseases, to ascertain the nature of the infection, as the contents of the tubes do not necessarily show the presence of gonnoccoci. Further still, so many marriages are followed by conception, that there must be some kind of recovery. However this may be, certain it is that many cases of subacute or chronic endometritis so supervene in which latent gonorrhœa is undoubtedly the factor. There may be no acute stage, but a gradual condition which ends in pyosalpinx or tubo-ovarian abscess, or both, with the awful consequences of pain, suffering, loss of health and sterility. This condition, with its gradual onset, but certain and sure destruction, is perhaps the most common cause of sterility. It is held by some observers that in chronic gonorrhœal infection, should conception occur, it is

likely to be of the tubal variety. This is a mooted question, but apt to be true in some cases. When the uterus and tubes are involved, it is interesting to know the efforts of nature to dispose of the results of infection.

The uterine ends of the tubes become closed and a pyosalpinx results; a true cyst, in fact. The contents of the cyst contain leucacytes, dead cells, gonococci, and various other pus-forming micro-organisms, the whole mixture making a whitish or *cafe au lait* mixture. The walls of the cyst are thickened by interstitial charges, and the peritoneal surface usually adherent to other structures. Under pressure and infection, the ovary breaks down and communicates with the cyst, making a true tube-ovarian abscess. The same process takes place on the other side, though from general appearances it would seem that the development of the infection is not simultaneous; that is, the process is much more advanced on one side than the other. In time, both sides become involved, though at the time of operation one tube may be normal. As time progresses there is a change in the cyst contents; the bacteria die, the leucocytes are absorbed, the mucous lining disappears, then the muscular coat, until finally there is nothing left but a large, thin-walled translucent cyst filled with a clear, limpid sterile fluid. This ruptures into the abdominal cavity, usually without pain or harm to the patient. Some years ago I presented three specimens before the New York Pathological Society which beautifully illustrated this transformation from the small, thick-walled cyst containing thick, creamy pus with gonorocci, streptococci, and many forms of bacteria to the one in of whitish contents and no bacteria, and finally the translucent thin-walled cyst with the limpid sterile contents. Most works on Gynecology are silent on this evidence of nature's disposition to do safe and bloodless surgery, but Bland Sutton and some French authentics treat exhaustively on this subject.

The real purport of this paper is to fix the responsibility of these infections where they belong and to urge the proper educational efforts on the part of the family physician. Asepsis in midwifery shows a fairly, well-settled proposition, but after an article on that subject in the *Journal of Surgery, Gynecology and Obstetrics*, of which I am editor, I read a note from an up-State physician which case ran on a febrile and uninteresting course. Truly, the ways of Providence are wonderful; wonderful, too, the assaults and outrages which a well-equipped human system will occasionally endure without protest. As to gonorrheal infection, a man is not to be condemned or legislated against because, perhaps in the ardor of hot youth he falls from the accepted moral standards. It is quite likely that as a consequence of repeated falls he will acquire a specific infection, his urethra; may consult his physician, and in the course of many weary months of experimentation with whatsoever may be the fad of his medical attendant, will discharge himself as

cured save the pearly morning drop that sits in the meatus urinarious to greet him as regularly as the morning star fades in the heavens before the approach of rosy dawn. He and the physician are both weary of urethal medication, and his case passes along about *in statu quo*. The rash folly of youth being spent, his mind now turned to the higher and loftier passion of pure love, he takes to his heart and bosom a pure woman to brighten his days and bear his children. But, alas! the bloom soon fades from her cheeks, the stars go out from her eyes, in place of smiles, the drawn and gray look of a septic woman, hospital instead of home, sacrifice of tubes, one ovary, and perhaps uterus, and the loss of all that is beautiful and lovely in married life, the consummation of love—maternity. The fire of ardent love burns low in that hearth, and across it smoldering embers and ashes, the dispelling of life's greatest illusion. Where is responsibility? With the greatest of sincerity I offer this for your discretion.

DISCUSSION.

DE WITT G. WILCOX: I want to endorse the very excellent paper of Dr. Honan, and I am sure it is through lack of time that his paper is not discussed. There are so many things to be said on that point that we could spend a whole afternoon on it very profitably, indeed; but I do want to corroborate that one idea, that it rests so largely with the physician to overcome this idea in the mind of the young married woman that she has some physical obstruction that would prevent her going to full term with her child. Every family physician, every gynecologist, every obstetrician, meets with just such instances as the Doctor has related, where the whole family will come to him and go through a long argument to show why it is going to be impossible for this woman to go through and have the child; and unless the physician will sit right down with those people and talk with them about the effects, and show them the ridiculousness of their position, that there is a strong probability in 999 cases out of a thousand that they will get through all right, those women will go off to the quack or the abortionist to be relieved; and it does rest very largely with the physician to overcome this prevalent idea.

REPORT

OF THE

BUREAU OF OPHTHALMOLOGY AND OTOLOGY.

"Splenic Lenkæmia: The Eye as a Possible Source of Infection," - - - - - - - - - W. H. DOANE.

SPLENIC LEUKÆMIA.

W. H. DOANE, M. D.,
ROCHESTER, N. Y.

J. D. Age 32. Occupation, clerk and telegraph operator. Family history, negative. Previous history: At the age of twelve was struck in the left eye with an arrow. Did not notice any diminution of vision until four years later, when he attempted to look through a crack in a barn door, and noticed that he could not see as well with the left eye as with the right one. There has been a gradual decrease in vision since about two years ago.

He came to my office on a matter of business. I asked permission to look at the fundus of the eye. I found several large white spots entirely denuded of choroid. The media was clear, with numerous particles of choroidal tissue floating in the vitreous. Vision was absent in the principal optic axis, but could see objects near his feet and to the left of him.

August 21, 1906, patient came to my office suffering from an attack of Uveitis that lasted several weeks. The lens had become opaque, which later appeared like a mass of pus behind the pupil.

I did not see the case again until December 27th, when he reported that he had not felt well since the inflammation subsided in his eye last August. About November 1st, he said that he had severe pain in left hyperchrondriac region that lasted several days before his local physician could give him relief. He returned to work, but gradually became weaker. He complained of feeling a lump in his abdomen, and asked me to examine him. I found an enormously enlarged spleen, extending beyond the median line.

The patient was very pale. Digestive symptoms negative. No change in the fundus of his good eye. He is now wearing —1 sphere for right eye. Diagnosis of splenic leuchæmia was made. The blood examination at this time by Pathologist Bidwell is as follows:

Hæmaglobin—50 per cent. relative. Seven grams absolute.
Coagulability—slow; color, pale muddy.
Specific gravity—1.040.
Microscopically:
Erythrocytis—2,230,000.
Poikilocytosis—rouleaux imperfect.
Leucocytes—295,196; cells unequal in shape, all forms are degenerated.
Lymphocytes—30 per cent.; large, 18 per cent.; small, 12 per cent.
Myclocytes—52 per cent.; degenerating neucleus; hydrops neucleus.
Eusinophiles, 2 per cent.
Polyncuclear leucocytes—16 per cent.
Diagnosis: Acute splenic leuchæmia.

This dismal picture was sufficient to put me on the anxious seat, and I began to sit up and take notice. X-Ray treatment was begun immediately.

Remembering that the patient's gradual decline dated from the time of the acute inflammatory exacerbation of left eye last August, I reasoned that there might be a relationship between this useless organ and the leuchæmic state. I therefore recommended its enucleation, which I did January 10th. There was slight hemorrhage following the enucleation. This was due to the enormous increase in the leucocytes that quickly formed a blood clot. Extreme swelling of contents of the orbit occurred in a few minutes, which continued until the mass assumed an enormous size, measuring about three and one-half inches in diameter, and bulging forward. The tissues became neurotic, but healed after some sloughing.

Then another examination of the blood was made which showed the following:

Hæmoglobin—75 per cent. (relative); 10.5 grams (absolute).
Specific gravity—1.055.
Coagulability good. Color fairly good.
Microscopically:
Erythocytes—3,280,000.
Poikilocytosis—rouleaux imperfect.
Leucocytes—84,739.
Lymphocytes—17 per cent.; large, 13 per cent.; small, 4 per cent.
Polyneuclear leucocytes—48 per cent.
Myclocytes—29 per cent.; eusinophilis, 5 per cent.

The polyneuclear leucocytes are deficient of neutrophile granules. Subdivision of neucleas.

Blood shows marked improvement in every respect.

You will observe from this report of last blood analysis that patient shows great improvement, notwithstanding the fact that he had a temperature of 103 on the fifth day, and 104 on the sixth day after the operation. The spleen is gradually diminishing in size.

X-Ray treatments have been stopped for the past two weeks on account of a superficial burn. Remedy: Baptisia; nourishment mostly proteids.

I believe that we would not have had so great an improvement in so short a period of time had not the principal exciting factor been removed.

The eye was referred by Dr. Bidwell to Dr. B. H. Stone, of the Laboratory of Hygiene, Burlington, Vt., who reported as follows: "The eye specimen had been shaken to pieces when it reached here, and consequently the exact relations were confused. The portions which I could rescue from the debris, and section, were absolutely structureless, and looked to me as much like the remains of an old blood clot as anything else.

Would it be possible that a hemorrhage had taken place in the eyeball and that organization had commenced to take place? A more definite diagnosis is not possible from the material and the condition in which I received it."

The obscurity of the etiology of leucæmia is my chief reason for reporting this case, thereby adding my mite to the only method that we have in unravelling the mysteries of the etiology of disease, which consists of utilizing every bit of evidence that may come to our notice through constant observation of the phenomena of disease processes. I believe that ultimately we shall be able to definitely locate the cause of leucæmia in an infection or a metamorphosis of some tissue of the body.

DISCUSSION.

GEORGE F. LAIDLAW: I might say a few words briefly on leukæmia. The Doctor's paper contains a well-proven and important link in the study of splenic leukæmia. The location of the leukæmic lesion is, I think, the bone marrow, and it is undoubtedly an infection of the bone marrow; but as far as I am aware, in other cases of leukæmia the primary source of infection has not been made out. It may well be that there is no particular microbe characteristic, but the changes in the bone marrow look like an inflammatory process. It is probably inflammation of the bone marrow that disorders its physiology and permits the escape into the blood of thousands of these immature leukocites. As I say, in our present knowledge, we do not know what kind of infection it is, but it looks as if it were an infection of the bone marrow from some primary focus.

You had a pus infection of the eye, Doctor?

DR. DOANE: Yes.

DR. LAIDLAW: An active pus infection of the eye? Of course, considering the thousands of infections we have about the body, and the rarity of leukæmia, it is, to my mind, not probable that the

pus infection of this eye had anything to do with the leukæmia, considering the fact that if pus infection had something to do with the leukæmia, we would have noticed it in the other cases of leukæmia that have been under observation; because pus infection is a fairly easy thing to detect from primary sources. But it certainly is an interesting case to see that sequence.

I do not think that the Doctor can surely attribute his improvement to the enucleation of the eyeball, because many cases do get well rapidly on the X-Ray treatment alone. So that while it is undoubtedly wise to eradicate that focus of infection, I scarcely think that all the improvement should be attributed to that. I should be inclined to attribute it to the X-Ray.

GEORGE A. SHEPARD: I have never seen any marked systemic results from my cases of panophthalmitis, and in my reading I do not remember any case of panophthalmitis with marked disturbance. In those cases where we do have infection from the abscess in the orbit, it is usually localized in the skull, in most cases I remember, which it does not seem to me in this could have been the cause.

DR. DOANE: Of course, I thought that perhaps these pathologists might think that this was merely a coincidence, but you will notice that the patient had been under the X-Ray treatment for weeks, that we had not noticed so very much improvement until after the enucleation of the eye. As I mentioned in the report of the case, I merely submitted it as an evidence, possibly, of the source of the cause of the difficulty.

Referring to Dr. Shepard's remark, that nearly all lesions that are caused from eye infections are located in the immediate vicinity of the brain—that, of course, is true, but I believe that when you study the anatomy of the eye, taking into consideration its limited blood supply, it is just as possible to get systemic disturbance from eye infection as from other sources. Still, for some reason or other, we do not get it as a rule.

There is one fact that I did not mention in the case, and that is that the only lymphatic enlargement that I could discover was in the submaxillary region. That would possibly indicate a general infection of the lymphatics.

REPORT

OF THE

BUREAU OF LARYNGOLOGY AND RHINOLOGY.

"Submucous Resection of the Septum," - - - A. WORRALL PALMER.
"Breathing," - - - - - - - - - - FRED D. LEWIS.

A LEGITIMATE FIELD FOR THE SPECIALIST.

A. WORRALL PALMER, M. D.,
NEW YORK CITY.

Under such a heading there appeared, about six months ago, a very interesting editorial by Dr. Strickler in *The Progress*, in which he clearly demonstrated, as most concede, that the diseases of the ear was a legitimate field for the specialists, because of the serious and fatal results of some aural diseases which not infrequently follow apparently trivial beginnings.

For quite a time I have been wondering if the diseases of the nose and throat were also a legitimate field for the specialist.

The writer being a practitioner in this department, you may consider his judgment warped; therefore, instead of endeavoring to give a logical or illogical array of his personal reasons and arguments for the above, he will make this paper more a collection of observations of facts or occurrences which come to the notice of a specialist.

Physiologically or pathologically considered, I think we all agree that either the normal and diseased conditions of the nares, pharynx and larynx play no unimportant part in healthy and diseased conditions elsewhere. The normal action of these cavities goes far to keep the lungs healthy. Through them the seeds of measles, scarlet fever, diphtheria, rheumatism, and several other bacterial diseases frequently if not usually and exclusively, enter the organism. In health, nature has providentially provided the nasal mucus, and the normal (mark I say, the normal), secretion of Waldeyer's lymphatic ring (the tonsils) with a strong phagocytic action, counteracting the deleterious effect of the microbes constantly in the air we breathe. But sufficient is this along this line.

While it is conceded by the profession as a whole, and the better educated portion of the laity, in their thoughtful moods, that the best of care should be taken of these organs, still does the actual

conduct and practice of the majority of these classes in the regular routine of life indicate that they carry out their belief.

First notice the public. They deem the corner druggist sufficiently competent to care for ninety-five per cent. of their troubles in this locality on account of their almost universal application to that dignitary for a patent medicine for "a cold," sore throat, etc., etc., when if the very same individual had an attack of colic he would hie himself to the doctor, for fear it might be appendicitis, or visit the chiropodist for a painful corn.

Secondly, if we take a casual glance at the medical profession at large, and if the old adage be correct that actions speak louder than words, they indicate that they do not consider that the nose and throat is a legitimate field for a specialist, or else that all are specialists in this line, because almost every mother's son of them sport an imposing spray and nebulizing apparatus, with snares, cautery points and tonsillitomes mixed promiscuously with catheters and uterine speculæ, etc., in their instrument cabinets or drawers, and treat any case of these conditions which presents.

Thirdly, allow me to state a few clinical cases taken from six months' experience. Will give them as concisely as is consistent to show the way in which they impressed the observer.

Case I. Young lady, referred by a very good homeopathic prescriber, who had been treating her by internal medication for one and three-quarters years for otitis media suppurativa dextra, with loss of almost half of the membrane tympani. I scarcely think my remedies a closer similimum, but their being supplemented with cleansing and local application, ordinarily employed by the specialist, cured the case in six weeks, against a record of about eighty-eight weeks.

Case II. Boy 16 years, having a general catarrh of nares to trachea, including the sinuses Objectively, rhinitis hyperplastica. Although nares of a broad variety, the hypertrophy was so extreme that all turbinates were in contact with septum, and the inferior with the floor of the nares, making of him a typical mouth-breather. The entire loss of physiological contractility of erectile or vascular tissue of all turbinates, the excessive hyperæsthesia and general neurasthenic condition made me suspect masturbation to be one of his youthful shortcomings. Treatment administered was removal of lower half of all turbinates, followed by cleansing nares and maxillary sinuses and medication, supplemented with advice *in re.* masturbation, which advice I think did him some good, as his neurasthenic condition greatly improved. The neurotic factor made the treatment, of course, tedious—about four months. The family physician had been spraying and medicating for about two years. I'm afraid if it were not for the operative procedure and recognition of the reflex cause, we might have sprayed or locally treated him twenty-two years instead of two, with but meagre results.

Case III. A young girl, aged 13, after being treated by her family physician for over a year with sprays and medication, was

referred to me for adenectomy. Examination showed hyperplsatic rhinitis, instead of hypertrophied adenoids, similar to the above, except minus the factor of genital irritation. Recognizing that the main cause of her catarrh was the irritation of the opposing surfaces of the nares and interference with drainage, a partial removal of inferior and cautious cauterization of the middle turbinates with a couple of months' treatment effected a cure.

Case IV. A clergyman, aged 36, called, complaining of throat fatigue on any speaking or singing, and aphonia lasting from half to two days on any lengthy use of voice. He said he had been treating with a general practician and specialist with sprays principally. Examination disclosed the septum markedly deflected to the right, and in left nares compensatory hypertrophy of both turbinates extending beyond the median line. Those deformities so occluded the nasal cavities that they robbed them almost entirely of their reasoning functions. Advised, first, removal of the projecting portion of turbinates, and second, straightening of septum.

He returned fifteen months later, in despair, saying he was no better, although he had had a specialist in his church perform the operation I had advised, and wanted to know if there was really anything to be done to save his voice. The church general practitioner-rhinologist had omitted to remove protruding turbinates before performing a Douglas operation, with use of splints, the ordinary two weeks, with result that a synechæ had formed between enlarged turbinates and septum. The septum had sprung back to its former malposition on account of neither using splints long enough nor being able to replace septum to the vesticle because of not previously removing the hypertrophies. Don't think me sacrilegious, but literally, "the second state of that man was worse than the first," because, supplementing the original condition, he had a synechæ and the calous, nature's splint. Both are difficulties to overcome in secondary operation.

The speaker gave identical advice he had previously. After explanation wherein it differed from the former operator, he had me operate, first removing the turbinates. When these were healed, the septum was straightened by means of the resection, or window operation. Of course, some local, electrical and internal treatment was necessary to alleviate the catarrh and strengthen the weakened muscles of the corda vocale. About ten months after discharge a favorable report was received. This patient might have been relieved of a second operation, waste of time, and not a little worry if his church friend had only thought over, not one of his several specialties, but the law of physics, sufficiently to recollect that two objects (the turbinates and septum) could not occupy the same space at the same time.

Case V. A trained nurse, complaining of oft-recurrent sore throats, consulted me. Examination showed a chronic follicular inflammation of a small amount of tonsillar tissue. From history of chronicity and the shortening of intervals between attacks, their

removal was advised. She answered, "Why that would be impossible, for they were all cut out six years ago." One physician had performed tonsillotomy, and two had subsequently assured her that no tonsil remained. One of the latter I, and I think a number of you, consider a man of more than mediocre attainments. The remaining lymphoid tissue was removed with result of no recurrences that winter. Operation last of October.

Case IV. Girl about 20 years consulted me for chronic deafness, which examination showed to be caused by eustachian obstruction, and this in turn by hypertrophy of the upper third of tonsils. This latter was not only detectable by palpation of anterior faucial pillar, but could be seen bulging that tissue forward. She had had her tonsils removed by an aurist. As in the former case, it required considerable argument to convince her she had any tonsil left, but I finally did. And the remaining portions of the faucial tonsils were removed. Subsequently, the ordinary inflation, massage and homeopathic medication were administered with the fair result of increasing the hearing distance for the accoumetre from ten inches to sixteen feet.

If the former aurist had more accurately studied the anatomy of the tonsil, finding one-third of it lying up above, external to the edge, and covered by the anterior pillar, he could have saved this girl the pain and cost of a second operation, and he would have received the gratitude which was left for me, instead of the reproaches which she showered upon him.

Case VII. Girl about 14 years, called giving history of a genuine attack of la grippe two and a quarter years ago, and followed by symptoms clearly indicating a left-sided, acute general nasal sinusitis. For nine months or a year subsequently she was subject to similar intermittent attacks; then it settled down to a continuous, slightly less profuse, still fetid discharge from left nares, while there was only a very moderate, distinctly pearly, bland discharge from the right side. Ever since the grippe she had been treated with sprays and internal medication. The patient had been informed that I would remove a polypus from the right side with a snare.

Examination disclosed a deflection of septum toward the left, occupying the anterior two-thirds and almost entire height of septum, in contact with the opposing tissues, and obscuring view of everything in the left nares except small slit on nasal floor and small portion of anterior extremity of inferior turbinate. The above deflection and contact of nasal tissues causing the sinus disease, which were by far the most important disease-producing factors, had been completely overlooked by the physician; while the usual occurring compensatory hypertrophy of the inferior turbinate was the object denominated polypus by the physician.

Advised first the removal of the hypertrophied right turbinate—calling it a polypus, because it is a good rule never to disagree with a referring physician in the presence of the patients and their friends—and advised, secondly, the resection of the septum, with

the explanation to the patient that there was a piece of bone which might be easily overlooked in an ordinary examination, and which caused some of the trouble.

These operative measures were carried out, followed by about two and a half months' local and internal medication, with the result of the cessation of all symptoms except a slight quantity of apparently natural mucus. Could not the proper and early recognition of the condition of affairs in the left nares and left nasal sinuses have saved the poor child a year and a half or more of suffering or discomfort?

Case VIII. A youth 24 years of age, presented himself with, as he described it, "a terribly neuralgic face ache on left side down into my teeth," duration, intermittently for fourteen to sixteen days. He had been treated medically by an allopath, and then one of the assistant surgeons at the Ophthalmic Hospital treated him privately with static electricity. All symptoms pointed strongly to a confined maxillary empyema, and I must admit that with as clean a case as this, I was somewhat surprised that our assistant surgeon had not even suspected the real condition. Suffice it to say that removal of the anterior portion of the middle turbinate, enlargement of the natural osteum, catheterization of the antrum, removing considerable odorless purulent mucus, gave him almost immediate relief of his pain, while the thorough cure of this subacute sinusitis occupied about two weeks. Had not the assistant surgeon given almost his entire time and attention to general practice, would not this patient been relieved of several days' suffering?

Case IX. A lady aged 41 years, complained of frequently-recurring excruciating neuralgic headache in lateral temporal region; also lesser pain extending from the throat to the back of ear, great tendency to "colds in the head" and continuous profuse mucopurulent discharge from anterior and posterior nares. Her suffering commenced as a sciatica; but this had been cured homeopathically about four years ago, when the neuralgic pain changed to the present locality. Polypi and some other tissue had been removed with temporary moderate relief by two different ophthalmological rhinologists of no small repute, one of whom assured her there was nothing more in the nares to be removed or done to relieve her condition.

Examination showed a slight hypertrophy of both inferior turbinates, a very peculiar deflected septum situated entirely in the upper half, completely within the concavity of which was a hypertrophy of a right turbinate. This right, as well as the left middle turbinate, were in contact throughout their full length with the septum, and the lateral wall of nares, thereby occluding both nasofrontal canals. Diagnosis of double frontal and ethmoidal sinusitis was made. Double middle turbinectomy and curettage of both ethmoidal labyrinths, leaving a large opening in floor of the frontal sinus, and resection of the deflected septum were performed at dif-

ferent times with almost immediate cure of neuralgia and material diminution of nasal discharge.

In conclusion, the speaker wishes to say that he does not believe his experience uncommon or unique for a specialist. Doubtless, similar ones come to the attention of all specialists in whatever line they practice. Neither does he wish to infer any superior ability in diagnosis and treatment over that which should be possessed by any one practising within this limit as a specialist.

May we urge that the family physician generally would familiarize himself more fully with the objective appearance and diagnosis, in order to better judge which cases may be amenable to the ordinary local methods of treatment, and which cases require the maturer judgment and the more technical- manipulation of the specialist, thereby frequently relieving the patient of a long, unnecessary trial of the universal, but oft-inefficient course of spraying; and relieving themselves of the not infrequent reproachful thoughts of the patient, when the latter finds himself cured by a comparatively short, properly-directed course of treatment?

Finally, if such cases as the above occur in a half year's experience of one lone rhino-laryngologist—and others probably have like ones—does it not seem reasonable that the intricacies of the upper respiratory tract, and the untoward and far-reaching harmful effect of the diseases in this domain would indicate that the nose and throat is a legitimate field for a specialist? And let one and all of us give a little more thought to the progress of medical science in the treatment of diseases within these limits.

DISCUSSION.

FRED D. LEWIS: I have expressed myself before, not before this Society, however, but in private conversations with physicians and patients, to the effect that I think the time is coming when the family physician will be considered as a consultant; that a patient presenting himself to the family physician with difficulties of any kind will be referred to the ophthalmologist, the laryngologist, the stomach specialist, the gynecologist, the surgeon, and so on, whose reports will be returned to the family physician, who will then use his judgment for eliminating all possible special difficulties. Whether the general condition may not be dependent entirely on, we will say, a nose difficulty, that field of specialism is not yet broad enough. That the nose and throat, the upper thoracic tract, is certainly a legitimate field in specialism, there is, in my opinion, no question. But it seems to me that in the future the field of specialism will be broadened, and taking the patient who is unwell, the treatment will be that of eliminating all possible reflex conditions, or outside conditions, and the function of the family physician will be one of consultation, rather than one of treatment.

BREATHING.

FRED D. LEWIS, M. D.,
BUFFALO, N. Y.

Did you ever stop to consider how vitally important to the continuance of life is this function of breathing? Men have been known to live for over a month without food; for over a week without water, but without air, life is measured but in minutes.

I do not propose at this time to enter into the uses air is put to in the economy, for all are familiar with the lungs' action and the oxidation of the red blood corpuscles. I do wish to remind you, however, that if the air we breathe was absolutely pure, there would be a complete absence of many of the diseases that we are constantly fighting. It is an acknowledged fact that such diseases as small pox, tuberculosis, scarlet fever, diphtheria, measles, whooping cough, typhus fever, and many others, are conveyed from one individual to another through breathing air charged with bacilli of the special disease.

Now, what has nature done to protect us from such invasion? The nose was placed on the face, not for ornamental purposes, but for a particular use. Its object was to add heat and moisture to the inspired air, and to remove any impurities that were not of a gaseous nature. If, therefore, the nose is not being used for the purpose intended, it is a violation of nature's law, and punishment must follow in permitting infecting germs to enter the lungs through the large cavity of the mouth, and thus enter into the circulation.

The conditions that may interfere with nasal breathing are various, the most common being growths, deformities or foreign bodies within the cavities. Another and no less important result of mouth-breathing in growing children is the development of the arched palate, which changes the position of the teeth, so that imperfect mastication results with its endless troubles dependent on impaired assimilation.

Another of the results that may follow improper breathing is the involvement of the eustachian tubes through insufficient aeriation, causing middle ear trouble with reduced hearing and annoying tinnitus.

With but these few points in view in regard to breathing, is it not the duty of the family physician to observe, when paying his visits to his patients, the various members of the family, especially the little ones, and note if they appear to breathe properly? If some member jokingly alludes to some other who snores in sleep, it should not be taken lightly, but should be investigated and the cause of it found. If the one alluded to is a child, the chances are nine out of ten that adenoids and enlarged tonsils are present, and

the sooner removed the better for the subject. If any of the turbinated bodies are enlarged, they should be attended to, and if the septum is so far deflected as to impair the breathing, it should be straightened. Should there be growths, such as polipi, they should not be suffered to remain.

Realizing, then, the importance of proper breathing, there is one other point I wish to touch upon. If it is of so much importance that the air we breathe should properly pass through the nose, it is equally important that the nasal mucous membrane should be kept in the proper condition to do its work. A few years ago I presented to this Society a paper on "Sprays." My ideas expressed then in regard to the habitual use of a spray to prevent catarrhal conditions, rather than wait for their development and then try to cure them, have been strengthened, and I am more positive in my views.

Living, as most of us do, in an atmosphere filled with smoke and dust and impurities, there is no earthly reason, in my mind, why the mucous membranes should not receive the same attention as the skin and the teeth. Physicians generally advise a certain amount of water to be taken between meals, that the general system may be flushed, and so prevent accumulations of waste products, and in certain cases of constipation that enemas be used. It seems to me quite as important that the membranes lining the nose should be as carefully looked after.

For this purpose any mild, saline, antiseptic solution may be used, carried to the parts with an atomizer. I am particular that an atomizer should be used, as the use of the douche or snuffing from the hand cannot, I think, fail to injure the delicate cilliary processes which form part of the epethelial cells, and whose action is to carry the secretions downwards and out of the nostrils.

I am not attempting to present to you in this paper any new matters for consideration, but to simply call your attention to a subject that most busy doctors are neglecting because they do not themselves realize the great importance of that little organ, the nose, or because they take it for granted that everyone knows his or her nose.

It seems to me, also that the time taken occasionally in reviewing subjects that we have heard before, and which have been gradually relegated to the only-occasionally-used brain cells, and bringing these subjects to the light for another consideration, is time that is not altogether wasted.

DISCUSSION.

A. WORRALL PALMER: I would like to endorse the general trend of Dr. Lewis' paper as strongly as possible, and would like to add just one word on sprays and douches in expression of my personal opinion. I think the Doctor is correct in saying that as

a preventive spraying the nose is very efficacious, but from my experience, when the nasal mucous membrane is taken out of pathological action, and is secreting the ordinary mucus, etc., not only the naso-pharyngeal, but pharyngeal, the ordinary viscid mucus, it seems to me that the sprays are almost inoperative. They will clean some of the mucus off of the surface, but they do not clean it thoroughly. The mucus is so tenacious that it seems to me it needs a sort of flushing action, as well as just to merely wipe over the surface, which is done by the spray, in order to remove it from the nose. It therefore seems to me that for a preventive the spray in the nose and the pharynx is efficacious, but when we come to the pathological diseased conditions of these organs, we need something more than the spray to obtain the effect that we are working for.

GEORGE A. SHEPARD: I would like to ask the cause of the prevalence of deviated septum. It is the contention of the essayist that frequently imperfect occlusion of the teeth causes faulty development of the superior maxilla. With the narrowing of the arch comes elevation of the nasal floor and consequent buckling of the septum. I have seen several cases in which appliances put upon the teeth have broadened the arch and brought about proper occlusion, with marked improvement in nasal breathing, as well as in digestion.

A case that I speak of with a certain degree of shame came to my hand two or three months ago. A boy was treated in my clinic for suppuration of the middle ear. He presented such a perfect picture of adenoid face, I advised, without examination of the vault, that he have his adenoids removed. He was put under the anesthetic, when digital examination disclosed the fact that there were no adenoids present. The arch of the palate was not more than two-thirds the normal width, thus forcing up the nasal floor.

It seems to me there must be some reason for the prevalence of faults in the septum. Although it is good to know how to operate upon deviated septum, when it is best to remove or not remove the the turbinatives, yet if we can find the cause of these troubles, we are, I think, going to do humanity more good.

FRED D. LEWIS: In regard to Dr. Palmer's remarks as to the douche, I think the only safe douche is the post-nasal douche. Sprays will not do everything. As we all know, the epithelium lining the nose are ciliated, and the cilia tend to carry the secretions down and outward. If we oppose nature, we get into trouble. The douche in many cases is necessary, but it must be used post-nasally.

As to deflected septum, which Dr. Shepard speaks of, I think in every instance we have an arch elevated to a greater or less extent, and the treatment is the broadening of the teeth and the lowering of the upper arch in that way.

GEORGE A. SHEPARD: Is that matter looked into sufficiently by rhinologists?

FRED D. LEWIS: It is not.

PROCEEDINGS

OF THE

Forty-First Semi-Annual Meeting of the Homœopathic Medical Society of the State of New York, held in Brooklyn, N. Y., Tuesday, Wednesday and Thursday, September 24th, 25th and 26th, 1907.

IN CONJUNCTION WITH

The Semi-Centennial of the Homœopathic Medical Society of the County of Kings.

PRESIDENT HERBERT DANA SCHENCK, of Brooklyn, called the Convention to order on Tuesday morning at 10 o'clock, in the Assembly Building, Nos. 153-155 Pierrepont Street, and introduced Rev. Robert Rogers, D. D., of the Church of the Good Shepherd, who offered the opening invocation.

PRESIDENT SCHENCK: We are very fortunate in having with us this morning a gentleman who needs no introduction to those of Greater New York, and scarcely to those who come from the more distant parts of the State—Hon. Bird S. Coler, President of the Borough of Brooklyn, who will welcome you to the City of Greater New York.

ADDRESS OF WELCOME.

BY THE HON. BIRD S. COLER,

President of the Borough of Brooklyn.

Mr. President, Ladies and Gentlemen: It gives me great pleasure to meet you here, and I feel very much complimented, on behalf of Brooklyn, that there are not more here at this early hour. It is such a bright day and Brooklyn is such a beautiful place, that you can hardly blame the absent ones for not coming earlier to a convention. I am glad that you have held your convention in the greatest part of the greatest city on earth. When Britain was joined to Scotland, that made Great Britain; and when New York was joined to Brooklyn, that made Greater New York. (Laughter.) Seriously speaking, there are more self-supporting people in this Borough than in any other city of the same size or in any separate

city of a million and a half of people. We have not the very poor, nor have we the very rich, but we are a tremendous city of homes, and growing at the rate of 130,000 people yearly. Few of you, when you come to the city of New York, realize what a city it is. Its population equals that of the entire thirteen colonies at the time of the Revolutionary War, and our expenses are about one-seventh those of the national government. With that phase I will not bother you, except to say that New York city is the most cosmopolitan city in the world to-day. There are more Irishmen in New York than in any city in Ireland except Dublin. There are more Germans than in any city in Germany except Berlin, and there are about as many Polacks here as there are in the whole of Russia; at least more than there are in Warsaw. So you can see what a tremendous cosmopolitan population we have. The growth of the city has been within 100 or 125 years, because at the time of the Revolutionary War the population of what is Greater New York was about 55,000. So, no city in the history of the world, not even London, Paris, Vienna or Berlin, has grown so rapidly as has the city of New York. New York has been the dumping ground of continental Europe. By that, I mean that almost all the immigration to this country has come through Castle Garden. In the last year or two almost one-third of certain nationalities have remained in the city, as you physicians of Brooklyn, who travel about through certain districts, thoroughly realize. So you can imagine what an undertaking it is to Americanize and assimilate these arrivals; and the wonder to my mind is, not that New York city is so bad, but that it is so good. Almost every one of you has traveled through Europe, and I have no doubt you will agree with me that New York city is a Sunday school compared to the great cities of continental Europe; but that is no reason why we should not be a great deal better. I know that the physicians of New York realize that on a great scale its charitable institutions and hospitals, both public and private, are improving conditions, and it seems to me that in the great cause of the advancement of mankind we must stand for the best things, and crowd out the bad things, by doing what is good. My newspaper friends here, I know, would rather put in their papers something good, if they could. That is the natural instinct of the newspaper reporters—to be decent, but often the paper doesn't want anything that is not sensational; so that on the construction of a great public library we can get one or two "sticks" of space sometimes, whereas when something is going on in a pool room somewhere, or a prize fight between a white man and a negro, you will get a whole page. So that constructive work, with the relations and attitude of the American press to-day, is a tremendously hard proposition. They are like the Irishman who came over in a steamer, and asked if there was a government here, and when he was told that there was, he said, "Well, I'm agin it;" and that is the condition very largely with the press with regard to great constructive policies.

In concluding, I would like to say that if you find time, I hope you will not only go over Brooklyn, but go over New York city, and take in the great things in our city that have not always been started or created by politicians or public men, but have been created by the people themselves. Forty years ago three or four gentlemen, including Mr. Samuel T. Avery, got together and founded the Metropolitan Museum of Art, and to-day it ranks in importance with those of continental Europe; and I had the pleasure of being present with a gentleman just before he drew his will, consulting about it, in which he left five million dollars to the city of New York alone—Mr. Rogers, of the old Rogers Locomotive Works—for the Metropolitan Museum of Art. So with the Museum of Natural History, almost as extensive as the other. Few people of our population realize the tremendous value of these great institutions, and through the professional people we can hope to disseminate that knowledge and a realization of the great education that can be derived from them.

I have not been able to consult with your President, but if the members of your convention would like to take a trip down underneath the river some day, I would be glad to arrange that for you. If you would like to get down among the men in the tubes, It would seem to me it would be a matter of great education and interest to you. I thank you all for coming here, and when you go back home and meet anyone that wants to come to the city of New York to live, send them over to Brooklyn.

RESPONSE FOR THE SOCIETY.

By President Herbert Dana Schenck.

Mr. President, I thank you for your cordial and kindly welcome to the second largest borough of Greater New York. Through the graciousness of the post office department and its own inherent growth and reputation as a city of homes, Brooklyn is known from one end of the State to the other. As the gateway to Long Island, I should not be surprised if some of our members have reason to glory in it, as they have gathered bounties from the real estate of Long Island while they have rested on its shores at vacation time, or watched others buy permanent houses in Brooklyn's suburbs, to their enrichment.

Our Society has no permanent home for its semi-annual meetings, which have been held in almost every part of the State, from Brooklyn to Buffalo, and from Pennsylvania to Canada. Wherever a group of our members find it to their advantage and ours for us to tarry, we pitch our camp for several days each autumn.

This is the sixth time since this Society was incorporated in 1862 that the generous physicians and citizens of Brooklyn have entertained us, exceeding every other town in the Commonwealth, except Rochester, which has also entertained us six times. This borough has also been honored with the presidency of this Society seven times since its organization in 1850.

Those who were fortunate enough to be here at our jubilee celebration seven years ago will scarcely recognize your borough, so much improved are its business and public buildings, and the disappearance of the famous cobble stone pavements, not to mention the great spread of its residential area since then.

If our Society could have been here a few weeks earlier they could have seen how well your borough is living up to its ancient traditions as the city of churches, by journeying to Coney Island some Sunday (even though the round trip did cost them twenty cents), and seeing how the gospel of pure air and innocent amusement is dispensed, with a setting of ocean view nowhere else approached. They could have gone home with a new idea of how far ahead this famous original is of their imitations.

I assure you that the generous hospitality you have extended will not be abused, even though it is extended to such privileged characters as doctors. This is the time when we have come to preach, and not to practice, and when we have finished our three days of work, we hope to leave something which will advance the standard of medical knowledge, particularly of Homeopathy, which we were organized to protect and develop.

Largely through your efforts, Mr. President, the homeopathic profession in this great borough enjoys to-day the advantages of a public hospital. The many private hospitals, homes and asylums under the care of this school of practice in this city, testify to the solid belief of your citizens in Homeopathy.

While the profession is not united, its members are coming to feel a greater tolerance for their differences in belief and to a general agreement upon educational lines that promises well for future united, harmonious work.

For your warm greeting and the extension of your liberal hospitality, which we are most happy to accept and make the most of in our brief stay, I can thank you no better than to say that "We would be little grateful if we should say how much."

ADDRESS OF THE PRESIDENT.

HERBERT DANA SCHENCK, B. S., M. D.

In order that there may be no misunderstanding or misconception regarding medical legislation last winter I desire to present a few facts regarding the valiant fight we conducted for your cause in our efforts to prevent any change in the system of State licensure of practitioners of medicine.

Since 1892 there have been in this State three examining boards representing the Homeopathic, Allopathic and Eclectic schools of medicine. The present law replaces these with a single board of nine members. Under the old law the appointments were made by the Regents from *nominations* made by the respective State societies, and precedent has always made it the rule of the Regents not to appoint anyone connected with the various medical colleges as a teacher.

This method of nomination secured the consideration of representative men, who were picked by a committee before their nomination, after considerable discussion many times. The present system makes it possible for the Regents to pick personal candidates.

The law is further removed from any medical suggestion by its failure to limit the Regents in their appointments, except that the candidate must have been a legal practitioner for at least ten years.

How have these changes affected us as a school?

1st. It has taken from us the prestige of being recognized as a school of medicine by the law of the State. What the ultimate effect will be is an academic question which has many debaters on both sides.

2d. Our students no longer go before a board of the same faith as themselves, but if their names are kept perfectly incognito, this can result in no injustice or favoritism.

3d. There is no examination in therapeutics; all the student gets in this branch being the teaching of the colleges which are left entirely on their honor in this vital branch, while they are compelled to maintain a standard that will permit their students to pass licensing boards in all other branches.

The forces behind this measure were two.

1st. The A. M. Association, which has been exerting all its influence for several years to pass laws similar to our present one, in all States where there were three boards.

2d. The Educational Department of the State of New York, which took the ground that it was overworked, and found various pseudo-medical bodies demanding examining boards which a single board would bar out. None of these bodies seemed ever likely to succeed except the Osteopaths. The Educational Department was so urgent, however, regarding a single board, that it called a conference of the representatives of the three schools, in the fall of 1905, to discuss it. The Homeopaths and Eclectics so vigorously opposed it that the measure was put aside for the time.

Mr. Howard J. Rogers, the First Assistant Commissioner of Education, was the moving force in having a single board bill introduced in the spring of 1906, which failed of passage. This was put in to act as a counter to the Osteopathic Bill, which seemed to have a good show to pass. This same measure was introduced early in 1907 by the same forces. You had it before you for consideration at the annual meeting. At that time it was believed that the Senate committee was committed to the Osteopaths, who were not given consideration in that bill, and that the Assembly committee, made up largely of Allopathic physicians, with a druggist as chairman, were for the single board measure.

You decided, in spite of the active opposition of the minority, to instruct your committee to fight for the retention of the three-board bill, and refused to give your executive or legislation committee power to modify this action, should occasion require it, in order to protect Homeopathic interests. Had the bill remained as it was

then, probably the outcome would have been as satisfactory to us as it was in the previous year; but in March, Commissioner Rogers got together his forces and combined the salient features of the Osteopathic bill, then before the Legislature, with the single board bill, so as to legalize practically most of the Osteopaths now in the State, and provide for their future candidates in a more or less liberal way. The only important feature of the Osteopathic bill which was not incorporated in the combination was the one giving them compulsory representation upon the examining board.

This new bill completely altered the opposition to the single board bill, and brought both houses largely to its support. What might have been the effect of our introduction of a single board bill, providing powers for keeping the nomination of representatives upon the examining board in the medical organizations, providing for an examination in therapeutics as well as for compulsory representation of the minority schools, of course cannot be told. Your action at the annual meeting prevented such a plan from being even considered. When, in spite of our efforts, the bill passed both houses, we endeavored to present the matter to the Governor in such a way as to appeal to his sense of right and justice, and, in order that our case might have the best possible presentation, secured the services of a prominent and well-known attorney of New York city.

In spite of this, the bill became a law, and in considering the results several factors must be considered:

1st. That our fight secured, in spite of all opposition, representation for us on the board. This was a proposition that was presented as an amendment to the bill when its passage seemed inevitable, but we were unable to secure it. We made it one of our stoutest contentions that no schools should have a majority of the board, and this is the present condition of the examining board. As most legislators seemed to consider this a fair proposition, I am inclined to think that the Regents in their appointments will continue as they have begun, by giving the Allopaths 4, the Homeopaths 3, and the Eclectics and Osteopaths 1 each in the board of 9.

2d. That this bill could not have secured the consideration it had except for the incessant work of Commissioner Rogers. He had the advantage of being constantly on the ground, and of entrance upon the floor of both houses, not enjoyed by those in opposition. This and his position gave him great power.

3d. That the decision regarding irregular practitioners last winter made it almost certain that some measure which would legalize the Osteopathic practitioners would be passed. This seemed to be conceded by most of the legislators opposed to special legislation for Osteopathy. This made it much easier to get the combined osteopathic and single board bill considered.

In conclusion, I think we can feel that, as a school, we are protected as matters stand at present, and that we will be still considered as standing for a system of therapeutics that marks us as a distinct sect in medicine.

This Society is under great obligation to the chairman of the legislative committee which carried on this contest. He sacrificed hours of labor, time and money which you cannot repay.

REPORT OF THE NECROLOGIST.

DR. JOHN L. MOFFAT: Since the last meeting of this Society four members have died: John H. Otis, of Poughkeepsie; J. B. Lawrence, of Brooklyn; A. J. Butterfield, of Binghamton, and J. E. Russell, of Brooklyn. Obituaries are herewith submitted, together with one of William de la Montayne, of Kingston, who died August 11, 1906.

NOTE.—Detailed report, with obituaries, will be found in the Appendix of this volume.

REPORT OF THE COMMITTEE ON ATTENDANCE.

There was in attendance during the various sessions of the meeting 176 members, 26 visiting physicians and 48 visitors, a total of 250. Many came and went during the sessions who failed to register. Those registered were enrolled by counties as follows:

Albany County—J. Ivimey Dowling, A. B. Van Loon.

Broome County—Elizabeth Corwin, G. H. Jenkins.

Cayuga County—J. E. Snodgrass.

Chemung County—Reeve B. Howland.

Clinton County—F. S. Farnsworth.

Dutchess County—C. E. Lane, Wm. G. Birdsall, A. L. Peckham.

Erie County—DeWitt G. Wilcox.

Fulton County—W. S. Garnsey.

Genesee County—J. W. Le Seur.

Jefferson County—W. H. Nickelson.

Kings County—H. D. Schenck, T. W. Kastendieck, J. Lester Keep, S. G. Klink, G. W. Bartlett, L. A. Cort, H. J. Pierron, G. H. Iler, J. A. Stewart, W. H. Price, J. J Sutton, E. Rodney Fiske, W. B. Winchell, W. E. Rink, R. I. Lloyd, R. F. Walmsley, W. R. Iszard, J. C. Harrington, Roy Upham, H. B. Minton, Aug. Von der Luhe M. F. Fleckles, M. L. Turton, W. M. Butler, H. O. Rockefeller, G. G. Bishop, Wm. I. Love, G. S. Ogden, G. C. Jeffery, E. W. M. Cameron, J. G. Wright, E. H. Muncie, L. H. Muncie, H. C. Allen, W. H. Aten, Chas. E. Paine, W. C. Latimer, W. H. Pierson, Geo. F. Lazarus, H. C. Peckham, A. Bornmann, M. E. Richards, M. L. Lines, J. C. Wiggins, J. B. Given, H. W. Hale, S. Close, M. E. Potter, E. R. Bedford, B. L. S. Baylies, W. H. Freeman, L. S. Gillespie, N. Robinson, R. L. Wood, O. S. Ritch, E. Chapin, W. J. Shrewsbury, D. Simmons, J. L. Moffat, F. E. Hopke, M. C. Sisson, W. W. Blackman, A. G. Warner, W. S. Searle, E. Lowe, C. H. Woolley, C. E. Harvey, W. S. Rink, H. A. Sanders.

Monroe County—J. M. Lee, Newton M. Collins.

New York County—T. Franklin Smith, W. G. Crump, J. T. Simonson, R. Turner, E. D. Franklin, Hills Cole, J. H. Fobes, Chas. McDowell, A. F. Eife, L. R. Kaufman, F. W. Hamlin W. H. Dieffenbach, L. L. Danforth, E. C. Charles, G. W. McDowell, F. G. Ritchie, G. DeW. Hallett, C. H. Helfrich, J. B. Garrison, S. H. Vehslage, T. D. Buchanan, C. E. Teets, G. F. Laidlaw, J. W. Hassler, H. G. Sloat, G. A. Shepard, C. H. Generich, A. B. Norton, Irving Townsend, D. E. S. Coleman, J. P. Seward, G. B. Stearns, B. G. Carleton, Sprague Carleton, W. I. Pierce, H. P. Cole, R. F. Rabe, W. A. Dewey, B. B. Clark, L. Z. Buchholz, A. Berghaus, Annie S. Higbee, E. L. Hill, E. G. Rankin, E. H. Porter, J. E. Wilson, W. S. Mills, G. M. Dillow, W. H. Bishop, W. H. Van den Burg, J. W. Dowling, F. L. C. Dowe, S. F. Wilcox, Wm. F. Honan, J. Oscoe Chase, J. G. Haberle, W. H. King.

Oneida County—C. E. Chase, C. T. Haines, C. E. Alliaume.

Onondaga County—Otis M. Wiley, W. H. Leonard, W. I. Hartman.

Ontario County—C. A. Rowley.

Orange County—R. C. Woodman, M. C. Ashley, R. E. Mitchell, F. M. Cummins, E. Fancher.

Otsego County—H. Worthington Paige.

Queens County—F. E. Brennan.

Rensselaer County—H. L. Waldo.

Schenectady County—Louis Faust.

Suffolk County—A. R. Pettit, G. P. Sword.

Tioga County—J. T. Greenleaf, L. D. Hyde.

Tompkins County—H. H. Crum.

Wayne County—E. P. Thatcher.

Westchester County—H. G. Keith, Nath. H. Ives, I. J. Lane, E. W. Brown, G. P. Holden, C. E. Birch, E. V. Brown, C. J. Miller, D. J. Roberts, Joseph Hasbrouck, J. H. Beattie, M. R. Leverson.

Visiting Physicians—E. M. Santee Washington, D. C.; C. E. Walton, Cincinnati, O.; Royal S. Copeland, Ann Arbor, Mich.; W. McGeorge, Camden, N. J.; C. R. Brown, G. H. King, H. S. Lasser, S. H. Simon, R. E. Townsend, O. D. Ingalls, I. J. Van Horn, C. B. Bacon, J. L. Cordozo, Horace Packard, Boston, Mass.; J. P. Rand, B. A. Rosenfeld, A. C. Emmel, M. W. McDuffie, C. K. Deyo, C. Lloyd, S. S. Simmons, C. N. Payne, T. H. McClintock, E. H. Stewart, A. F. Erdman, R. T. Johnston.

Visitors—Hon. Bird S. Coler, Rev. Robert Rodgers, A. B. Weaver, G. E. Lane, J. Cumming, J. F. Knappy, A. L. Fox, C. T. Laird, G. Mason, Rev. J. W. Norris, G. Walker, W. B. Dalston, S. P. Thompson, H. Rosenberg, D. Wadsworth, A. O. Potter, C. F. Steinbuck, J. M. Wright, M. W. McNally; Mesdames Warner, Woodin,

Seeley, Ashley, Fancher, Lazarus, Jenkins, Brown, Rowley, Waldo, Farnsworth, Hyde, Porter, King, Wiley, Snodgrass, Hartman, Swords, Corwin, Bryant, Norton, Van den Burg, Dowling, Shepard; and Misses Corey, Brown, Bryant, Stafford.

Signed, NATHANIEL H. IVES,
WALTER G. CRUMP,
FRANK H. WRIGHT,
Committee.

REPORT OF THE COMMITTEE ON INCREASING MEMBERSHIP.

The Chairman, ORANDO S. RITCH, made the following report:

Mr. President and Members—I have to report at this time eighteen applications received. These have been filled out in the proper form, according to the requirements of the constitution, and each is accompanied with the regulation fee of $5.

I would further state that we have had several communications from physicians in the State who have been dropped in years gone by for the nonpayment of dues. Many of these are anxious to come back into the Society, and there has been a considerable misunderstanding on the part of various members as to whether they could come back as new members, by paying the new fee of $5, or what not. There are two or three of those communications which I wish to present to the Executive Committee for decision.

The Committee has mailed to every Homeopath in the State who is eligible for membership, and I presume that takes in all of those who are not already members of the Society, a communication on this subject, and from the responses that have been received, the Committee feels certain that between now and the annual meeting there will be a goodly number brought in, or their applications presented for your action.

REPORT OF THE BOARD OF CENSORS.

DR. NATHANIEL H. IVES, representing the Censors, reported that eighteen applications had been received, all in regular form, and each accompanied by the fee of five dollars, and were recommended for election to membership. The following is the list of names which latter were, upon motion, duly elected members of the Society:

NAME AND RESIDENCE.	ENDORSERS.
CHESTER R. BROWN, Metropolitan Hosp., *I, '07,	Orando S. Ritch, Edward V. Brown.
SPRAGUE CARLETON, New York, Mhn., I, '06, .	Bukk G. Carleton, H. W Paige.
FRANK M. CUMMINS, Warwick, I, '88, ...	W. W. Blackman, O. S. Ritch.
ARTHUR H. HARDY, Mount Vernon, I, '02, . .	Nathaniel H. Ives, O. S. Ritch.
JOSEPH AGATE HOUSE, Mount Vernon, IV, '80,	Nathaniel H. Ives, O. S. Ritch.
O. DUBOIS INGALLS, Brooklyn, I, '03, ...	John L. Moffat, W. S. Rink.
WALTER R. ISZARD, Brooklyn, II, '02, . . .	O. S. Ritch, A. Bowmann.
MARY P. JEPSON, Olean, III, '95'	Jos. H. Riegn, O. S. Ritch.
G. B. MACK, Auburn, I, '04, ...	J. Elmer Snodgrass, Hills Cole.
M. V. MCDUFFIE, New York, Mhn., I, '04, . .	Chas. Gennerich, W. H. Dieffenbach.

NAME AND RESIDENCE.	ENDORSERS.
S. W. PALLISTER, Brooklyn, I, '98, ...	H. J. Pierron, Alton G. Warner.
P. D. RIORDAN, New York, Mhn., I, '98, . . .	O. S. Ritch, H. W. Paige.
HAROLD A. SANDERS, Brooklyn, I, '05, . . .	W. B. Winchell, O. S. Ritch.
WILLIAM J. SHREWSBURY, Brooklyn, I, '81, . .	R. F. Walmsley, B. G. Carleton.
RICHARD E. TOWNSEND, New York, Mhn., I, '82,	J B. Garrison, O. S. Ritch.
ROY UPHAM, Brooklyn, I, '01, ...	O. S. Ritch, A. Bowmann.
ROBERT F. WALMSLEY, Brooklyn, I, '94, . . .	O. S. Ritch, H. W. Paige.
ROBERT LOWELL WOOD, Brooklyn, I, '04, . .	H. C. Allen, H. D. Schenck.

*I. New York Homœopathic Medical College and Hospital.
II. Hahnemann Medical College of Philadelphia.
III. Hering Medical College, Chicago.
IV. Eclectic Medical College of New York.

REPORT OF THE COMMITTEE ON LOCAL ARRANGEMENTS

The Chairman, ALTON G. WARNER, reported as follows:

Mr. President, Members of the Society—On behalf of the local committee and of the Semi-Centennial Committee of the Kings County Society, we bid you welcome to Brooklyn. The Committee is at your service. We want to make your stay pleasant, and to have you call upon us for any information or assistance that we can give you.

On behalf of the Ladies' Committee, I want to call the attention of the ladies present, and of the gentlemen whose wives are present, to the tea at Mrs. Blackman's at four o'clock this afternoon, and to ask that the visiting physicians, for their wives, will hand to the clerk at the information desk the names of the ladies who desire to go upon the automobile ride and luncheon on Thursday, and also to the theater party to-morrow afternoon. It is presumed, of course, that the ladies of Greater New York, who have this opportunity at any time, may not care to join these parties, which are primarily for the visiting ladies from up the State; but if any of the ladies from Manhattan desire to join either of these parties, and will give notice at the information desk, arrangements will gladly be made for them.

I would like to call the attention of members to the various hospitals that have extended their greeting to this meeting, and have also given a very cordial invitation to everyone who cares to visit any of them. Superintendent Bacon, of the Cumberland Street Hospital, will be particularly glad to welcome at any time any member of this Society who cares to visit that institution. The lady managers of the Brooklyn Home for Consumptives have given an official and very cordial invitation to the members to visit that Home, and if any of you are interested you can there see cases of consumption in all stages, and the staff stands ready to receive you at any time, if you will notify me or any member of the Committee. The same is true of the Brooklyn Nursing Infants' Hospital and the Prospect Heights Hospital, Washington avenue, which are open for your inspection, as well as the Memorial Hospital for Women and Children which is under the care of the women physicians of this city.

REPORT OF THE PRESS COMMITTEE.

In the absence of the Chairman, WILLARD C. DU BOIS, the President reported:

The Press arrangements have been made by the County Society by getting a newspaper man to take charge of them. The local papers have been given full accounts of our meeting since the first of August, and for the last week or two various statements regarding this meeting have been sent through the Associated Press to all parts of the State, and if any of the members of the Press Committee have received communications from the chairman, it was to aid the Committee in getting these despatches noticed in the local papers.

REPORT OF COMMITTEE ON EXHIBITS.

The Committee on Exhibits, through its chairman, begs leave to report on its work in connection with the forty-first semi-annual meeting, as follows:

Receipts: From rental of spaces at $20 each		$360.00
Expenditures:		
Architect's bill for plan of room	$10.00	
Postal, including stationery	4.54	
Addressing, mailing, etc.	2.10	
Telephonic communication, etc.	3.00	
Meyer Bros., printing	13.50	
The Assembly, Brooklyn	61.20	
Banquet Tickets	50.00	
Extra labor at Assembly, etc.	11.90	$156.24
On hand		$203.76
Assets: Rentals of six spaces		$120.00
Total (prospective)		$323.76

Respectfully submitted,

BERT B. CLARK,
Chairman.

NOMINATION OF OFFICERS.

The open-meeting nomination of officers for election at the annual meeting, February, 1908, resulted as follows: President, William S. Garnsey, Gloversville; First Vice-President Wm. H. Nickelson, Adams; Second Vice-President Frank E. Seitz, Buffalo; Third Vice-President, Robert C. Woodman, Middletown; Secretary, Bert. B,

Clark, New York, Manhattan; Treasurer, Reeve B. Howland, Elmira; Necrologist, John L. Moffat, New York, Brooklyn; Counsel, Edwin Van Wormer, Esq., Albany. The nomination of four Censors one from each District, was left to the Executive Committee with power.

REPORT OF THE COMMITTEE ON LEGISLATION.

The Chairman, JOHN M. LEE, submitted the following report on behalf of this Committee:

Mr. President and Members of the Society:

Your Legislative Committee would respectfully report that during the campaign recently closed we put forth unusual effort in the Society's work. It was evident shortly after the campaign opened that the objective point of the Allopaths was the annihilation of the Homeopathic School. In order to try to unite our forces with the Old School, a sub-committee from our Legislative Committee made a trip to Albany to confer with the Regents, Dr. Vanderveer and Dr. Root, chairman of the Old School Legislative Committee. We were informed that they, the Old School, desired to secure the passage of a single board bill to shut out the "fakirs," principally the Osteopaths. We urged an amendment to the three board law, defining the practice of medicine. Such a change in the law was carefully prepared by a prominent lawyer, and ten days later Dr. King, Dr. Boskowitz and other members of the Eclectic and Homeopathic legislative committees from the east, and a number of members from the west, again made a trip to Albany to try to have the amendment adopted by the Old School representatives. After a little discussion Dr. Root informed us that they would have nothing to do with any amendment, and that the only ground on which they would work with us in the legislature was that of a single board bill without Homeopathic or Eclectic representation. We withdrew from the conference and began our campaign in the Legislature.

When the Old School were hard pressed and their case seemed well-nigh hopeless, they formed an alliance with the Osteopaths, the Divine Healers and the Christian Scientists, and secured sufficient support in this way to defeat us.

The operation of the single board law is too brief to make it clear to us what the real effect will be, but there is every reason to believe that it will be detrimental to our cause. In fact, the movement is national, and our interests have been attacked in other directions. For instance, an effort was made to remove our school from both Iowa and Michigan universities. I saw a card admitting a young physician to the recent examinations, and it stated that they were under the auspices of the Medical Society of the State of New York.

Respectfully submitted,

Signed, JOHN M. LEE,

Chairman.

REPORT UPON THE SPECIAL LEGISLATIVE FUND.

BY THE PRESIDENT.

Your officers and Legislative Committee realized last spring that this legislative matter was one of the greatest importance, and that it had to be conducted necessarily at great expense. We made the best and most strenuous fight we knew how, to carry through the behest which you gave us at the last annual meeting—to save the three board bill if we possibly could. We spent money freely, and we did our utmost to protect our interests. You had the unstinted work of the chairman of your Legislative Committee, and he put hard work into this contest that you can never repay.

After this bill was passed and signed by the Governor last May, I addressed a communication to every member of this State Society, setting forth what had been done, the probable expense, and that it seemed desirable to meet this by a popular subscription, because I felt that this was a matter in which every man ought to feel that we were fighting for him personally; we were not fighting for any two or three, we were fighting for every one of the 550 members of this Society, as well as those Homeopaths who are not among our members. I anticipated that the bills of the chairman would amount to $600. As a matter of fact, they amounted to $623.

When matters became very strenuous last spring in Albany, we held an important meeting of the Legislative Committee and various other officers and leading members of this Society, at which we discussed all the phases of our opposition to this bill. It was the unanimous opinion of that meeting that the President should, in case the bill passed the Legislature, employ counsel to present the justice of your contention about the three boards to the Governor, that he might have grounds for vetoing the measure. When the bill did come before the Governor, I took that matter under consideration, and after consulting carefully with a great many members of this Society who were much better qualified than I to judge of men and their abilities, employed a well-known New York attorney who had been very active with the Governor in much of his reform work during the early part of the legislative session, a well-known member of the Republican Club of New York, and a man most likely to command the confidence of the Governor, if he could be influenced at all. At that time there was no probability of there being a public hearing. Nobody, so far as we know, ever applied for a public hearing. When some of our members, friends of the Governor, asked him to let them present our side of the case to him personally, he suddenly sent out a three days' notice that there would be a public hearing. That was all the time we had to prepare for it. We did the best we could. I think we made a very able presentation of the matter, and I think everybody felt that our legal representative had presented our case fairly, eloquently, and had given the Governor a fair chance to judge whether we had justice and right on our side. In spite of that, and the strong protest made by the Eclectic representative, the bill was signed,

I have given this somewhat in detail, that you may know the items of the expense account. The expense of the lawyer was $500; the expense of the chairman of the Legislative Committee was $623, and the members of the Legislative Committee have sent in bills amounting to $300. In 1906 the Legislature of the State of New York passed a bill requiring every organization that hired agents or had any work done in Albany upon legislative matters, to file within two months after the Legislature adjourned, a sworn statement as to its expenses during the campaign. We have on file in the office of the Secretary of State in Albany a sworn statement that we expended $1,423 during the fight.

After this was all over, and the Governor had signed the bill, I addressed a circular to every member last May, requesting each of the 550 to send me at least $2.00. I said "at least $2.00." I did not say that that was the *maximum*, I said that was the *minimum* that I expected from every member of this Society. I expressly stated that we needed and would gladly accept larger contributions of any amount. That brought less than a hundred men of the State Society as contributors.

In August I deemed it wise, in view of these unpaid bills, to send out a more urgent circular, in which I explained in detail the expenses we had incurred. I sent that to every member who had not contributed to this fund. At the present time I have received the sum of $701. The number who have contributed is 186 out of our 550 members, as follows:

M. O. Terry, M. D.	$25 00	
J. B. Garrison, M. D.	25 00	
B. G. Carleton, M. D.	25 00	
W. W. Blackman, M. D.	25 00	
C. L. Bagg, M. D.	25 00	
Edward Chapin, M. D.	25 00	
H. D. Schenck, M. D.	25 00	
Total		$175 00
John Moffat, M. D.	$10 00	
F. W. Seward	10 00	
W. F. Helmuth	10 00	
W. H. King	10 00	
Total		$ 40 00
C. E. Birch	$ 5 00	
W. H. Freeman	5 00	
W. H. Hodge	5 00	
E. H. Porter	5 00	
DeWitt Wilcox	5 00	
J. T. Simonson	5 00	
E. V. Brown	5 00	
Franklin Smith	5 00	
E. M. Brown	5 00	
R. A. Adams	5 00	
G. A. Shepard	5 00	
D. Simmons	5 00	
J. E. Wilson	5 00	
J. M. Lee	$ 5 00	
J. P. Seward	5 00	
W. A. Keegan	5 00	
A. B. Norton	5 00	
G. W. Roberts	5 00	
F. M. Dearborn	5 00	
R. F. Rabe, Jr.	5 00	
C. E. Lane	5 00	
G. C. Dominick	5 00	
W. N. Bell	5 00	
W. S. Garnsey	5 00	
J. T. Cook	5 00	
F. W. Hamlin	5 00	
Irving Townsend	5 00	
F. H. Lutze	5 00	
C. T. Haines	5 00	
G. W. McDowell	5 00	
G. W. Richardson	5 00	
C. R. Sumner	5 00	
E. P. Swift	5 00	
N. A. Mossman	5 00	
W. H. Pierson	5 00	
Total		$175 00
J. G. Baldwin	$ 4 00	
C. L. Johnston	4 00	
F. W. Adriance	4 00	
Total		$ 12 00

J. W. Le Seur	$ 3 00	
G. H. Jenkins	3 00	
G. F. Borden	3 00	
W. W. Cole	3 00	
L. Faust	3 co	
E. D. Franklin	3 00	
W. H. Krause	3 00	
N. Ives	3 00	
W. H. Nickelson	3 00	
T. Wiggans	3 00	
C. E. Teets	3 00	
G. W. Seymore	3 00	
M. C. Pardee	3 00	
R. Lount	3 00	
F. S. Farnsworth	3 00	
N. Hunting	3 00	
H. L. Waldo	3 00	
G. E. Tytler	3 00	
F. G. Ritchie	3 00	
E. W. Avery	3 00	
L. L. Button	3 00	
Wm. M. Butler	3 00	
Total		$ 66 00

G. Hartley	$ 2 00
J. McE. Wetmore	2 00
H. E. Street	2 00
W. I. Pierce	2 00
M. Besemer	2 00
R. E. Miller	2 00
D. A. McMichael	2 00
A. Berghaus	2 00
G. H. Smith, Jr	2 00
Mary E. B. Foote	2 00
A. A. Wemmell	2 00
H. C. Allen	2 00
B. W. Bierbauer	2 00
J. A. Stewart	2 00
G. H. Iler	2 00
J. G. Wright	2 00
R. I. Lloyd	2 00
G. F. Lazarus	2 00
H. B. Minton	2 00
G. S. Ogden	2 00
W. B. Winchell	2 00
J. B. Given	2 00
W. S. Rink	2 00
E. R. Bedford	2 00
A. G. Warner	2 00
L. L. Danforth	2 00
J. F. Land	2 00
E. G. Cox	2 00
J. W. Allen	2 00
Wm. Little	2 00
Thos. Parsons	2 00
S. H. Velohlege	2 00
E. C. Eddy	2 00
E. R. Fiske	2 00
W. H. Scott	2 00
H. J. Pierson	2 00
J. C. Shaw	2 00
W. S. Searle	2 00
C. C. Boyle	$ 2 00
H. V. B. Peckham	2 00
Geo. H. Smith	2 00
D. H. Arthur	2 00
H. W. Hoyt	2 00
B. B. Clark	2 00
E. C. Rankin	2 00
S. Hasbrouch	2 00
M. J. Hall	2 00
G. W. Crum	2 00
J. I. Dowling	2 00
J. H. Fobes	2 00
L. M. Stanton	2 00
M. C. Ashley	2 00
R. C. Conklin	2 co
L. S. Gillespie	2 00
A. J. Robbins	2 00
R. R. Trotter	2 00
O. D. Kingsley	2 00
A. G. Peckham	2 00
J. O. Chase	2 00
A. B. Kinnie	2 00
H. E. Russell	2 co
N. M. Collins	2 00
R. B. Howland	2 00
W. H. Bishop	2 00
J. S. Barnard	2 00
N. Robinson	2 00
J. G. Maeder	2 00
R. B. Covert	2 00
C. N. Guy	2 00
C. B. Walrad	2 00
H. O. Rockefeller	2 00
Wm. S. Rambo	2 00
L. D. Hyde	2 00
J. H. Hallock	2 00
Jos. Rieger	2 00
Chas. Alliaume	2 00
G. R. Cribchlow	2 00
E. Fancher	2 00
F. D. Lewis	2 00
S. R. Snow	2 00
W. C. DuBois	2 00
B. G. Clark	2 00
W. J. Candee	2 00
E. G. H. Beck	2 00
J. E. Snodgrass	2 00
A. J. Richardson	2 00
J. F. Ranken	2 00
I. L. Lane	2 00
G. B. Carter	2 00
S. W. Hurd	2 00
J. E. Tytler	2 00
A. R. Green	2 00
J. A. Mackenzie	2 00
H. Beals	2 00
D. B. Stumpf	2 00
E. E. Snyder	2 00
J. E. Slaugh	2 00
A. H. Rodgers	2 00
H. D. Cochrane	2 00
Peter Erb	2 00
H. P. Johnson	2 00

O. J. Travers	$ 2 00	B. W. Sherwood	$ 2 00	
J. M. Keese	2 00	A. Von Der Luke	2 00	
Emily Charles	2 00	O. M. Wiley	2 00	
J. H. Storer	2 00			
Chas. McDowell	2 00	Total		$229 00
T. D. Buchanan	2 00			
D. E. S. Coleman	2 00	*Wm H. Price	$ 2 00	
M. W. Johns	2 00	*M. T. Hopper	2 00	
N. H. Haviland	1 00			
D. J. Roberts	2 00	Total		4 00
H. G. Keith	2 00			
H. W. Paige	2 00	Grand Total		$701 00

Doctors W. H. Price and M. T. Hopper, of Brooklyn, contributed, although not members. Dr. Price is now a member.

Doctor Charles L. Bailey says he contributed his services in Albany, which is all he ought to do. Dr. W. H. Watson contributed his expenses of $30 or $40 as his share, and Robert C. Scott says his $3 paid last winter is all he feels he can afford. Several members who have contributed generously to this fund also made one or more trips to Albany to the hearings and to forward the work.

There, gentlemen, is the honor roll of the State Society at the present time. Now, this Society has got to make up by special subscriptions the rest of the money that is due for this legislative work, and I want you to distinctly understand that some of you who know what the value of this work has been have got to go to work somehow to get this money. You have either got to contribute it personally, or you have got to stir up your colleagues in your various county societies, for this money must be gotten. I, as president, feel an obligation to collect what I started out to collect—$1,000, or more, for this fund. Those of you who have not yet contributed to this fund will receive a third, and perhaps a fourth dun before I am finished with this. I propose to see that this thing is wiped out before I go out of office, if I can. (Applause.) Please understand, gentlemen, that this is a distinct business proposition, in which I am deadly in earnest, and if any of you feel as deeply in regard to this as I do, as to what has been accomplished, you will put your hands down in your pockets and come right up with your money. (Applause and laughter.)

SPECIAL REPORT OF THE TREASURER.

Mr. President and Members:

Upon request of the President, and in order that you might be informed as to the present state of the treasury, I have the honor to make the following report, as Treasurer of the Society for the period February 15, 1907, to September 24, 1907.

Received from Dr. F. M. Dearborn, former Treasurer of the Society, -	$ 328 08
" " Dr. Geo. E. Gorham, Chairman, Banquet Committee, Annual Meeting, - - - - - - -	174 00
" " Dr. B. B. Clark, Chairman, Committee on Exhibits, -	112 23
" " (23) Twenty-three membership fees, - - - -	115 00
" " (312) Three Hundred and Twelve membership dues, -	936 00
	$ 1,665 31

The following bills have been paid:

Second National Bank, Elmira, Check Book, - - - - - -	$ 1 50
Oneonta Press, Printing, - - - - - - - - - - -	212 75
Snyder Bros., Printing, - - - - - - - - - - -	9 00
Albany Commercial Printing Co., Printing, - - - - - -	1 25
Rochester Printing Co., Transactions, - - - - - - -	683 34
Pulis Printing Co., - - - - - - - - - - - -	34 25
H. J. Rockwell & Son, Annual Banquet, - - - - - - -	194 19
Dr. C. T. Haines, 1400 copies Utica Daily Press and Mailing, - -	59 19
Dr. E. H. Porter, Chairman Legislative Committee, - - - -	105 00
Dr. Hills Cole, Chairman, Committee on Increasing Membership, -	14 81
A. B. Weaver, Stenographer, Annual Meeting, - - - - -	85 30
St. Louis Button Co., Badges, - - - - - - - - -	27 00
Dr. Sutherland, Boston Expenses to Annual Meeting, - - -	12 00
Dr. Goodno, Philadelphia Expenses to Annual Meeting, - - -	18 00
Dr. F. M. Dearborn, New York Expenses to Annual Meeting, - -	9 40
Dr. Ethel M. Terrell, Clerk to Secretary, - - - - - - -	9 45
Dr. H. W. Paige, Salary 1st Quarter and Postage, - - - - -	77 15
Dr. R. B. Howland, Postage and Express, - - - - - - -	14 00
	$ 1,587 53

Total Receipts, - - - - - -	$ 1,665 31
Total Expenditures, - - - - -	1,587 53
Balance on hand, - - - - - -	$ 77 78

One bill, that of the Secretary for second quarter's salary, amounting to $75, has not been paid. I would like to announce further that there are 241 members that are back on their dues, to the amount of $1,000.

Respectfully,

REEVE B. HOWLAND,

Treasurer.

REPORT OF THE AUDITING COMMITTEE.

Mr. President and Members:

The printing, postage and Secretary's bills were found correct, and audited, also the bill of Dr. J. M. Lee, Chairman of the Legislative Committee, for $621.08. There are some other personal bills for railroad fare, hotel expenses, etc., incurred by other members of the Legislative Committee than the chairman, which we did not audit, thinking it better to leave the matter to the Society, there being no precedent established for paying them. These other bills (requested by the Chairman and handed in with his) of Drs. Adri-

ance, Couch, Birch, King, LeSeur, Candee, Cook and Martin, we leave for the Society to consider. The amount of these bills is $301.55 all told. There is very little money in the treasury, so we did not feel as though we should assume the responsibility of approving them.

Signed, J. IVIMEY DOWLING,
G. H. JENKINS,
J. B. GARRISON,
Auditing Committee.

The report of the Auditing Committee was received by the Society, and the printing, postage, Secretary's bills and the bill of the Chairman of the Legislative Committee were ordered paid. The bills for personal expenses of other members of the Lgislative Committee, to a total of $301.55 were, upon motion, ordered not paid.

VARIOUS RESOLUTIONS ADOPTED.

Board of Medical Examiners: Resolved, That we request the Homeopathic members of the Board of Medical Examiners to render an annual report to this Society. (Introduced by Dr. King.)

Thanking Kings County Society: Resolved, That it is the sense of the Homeopathic Medical Society of the State of New York that hearty thanks be tendered to the Kings County Society for offering and providing entertainment, and that the appreciation of this Society is hereby unanimously expressed. (Introduced by Dr. Le Seur.)

Eye-strain and Nasal Disease in Students: Whereas, eye-strain (even with normal vision), nasal obstruction, post-nasal adenoids, etc., seriously handicap a student in his efforts to secure an education;

Resolved, This Society respectfully urges upon the administration of every college and school the importance of impressing the above fact upon the whole student body at the beginning of each school year. (Introduced by Dr. Moffat.)

Sanitation for Public Schools: Whereas, Our public and private schools are and must be fertile centers of contagion; and

Whereas, No attempt to disinfect them by efficient methods has been made; therefore,

Resolved, That we respectfully urge upon our Boards of Health, our Health Commissioners, the Commissioner of Health of the State of New York, that all school buildings within their jurisdiction should be thoroughly fumigated or otherwise disinfected once a week during the current school year.

Resolved, That we also suggest the introduction, where practicable, of drinking fountains instead of cups in all public schools. (Introduced by Dr. W. S. Searle.)

Prevention of Blindness: Whereas, It has been known for a generation that the Crédé method of instilling two drops of two per cent.

nitrate of silver solution or of more recent methods of using Argyrol five to twenty per cent., into the eye of the babe at birth, is reasonably sure to prevent ophthalmia neonatorum; and

Whereas, This preventable disease is still destroying the sight of new-born children—seven per cent. of the blindness developed in the State of New York during the year 1906 being attributed to this disease;

Resolved, The Homeopathic Medical Society of the State of New York declares that the campaign of education should be pushed with vigor in all directions, that new laws should be enacted and existing laws enforced, and that it is the duty of each member of the medical profession to exert his influence in support of the N. Y. State Commission to Investigate the Condition of the Blind, of which Dr. F. Park Lewis, of Buffalo, is chairman;

Resolved, That we urge upon the Health Departments of the State and the cities of the State the enforcement of the law requiring a prompt report of each case of inflamed eyes in a child one week or less old, the distribution of circulars of advice to midwives and mothers, and that the nurses and inspectors be instructed to include ophthalmia and neonatorum and analogous ophthalmias in their inspections, reports, treatments and instructions. (Introduced by Dr. Moffat.)

Free Diphtheria Antitoxin: Whereas, The mortality from diphtheria has been markedly diminished since the introduction of the use of diphtheria antitoxin,

Whereas, The best results are obtained when it is used early and in sufficient dosage,

Whereas, The use of diphtheria antitoxin is believed to be a valuable prophylactic measure,

Whereas, The present commercial price of antitoxin militates against its early use in sufficient dose by all but the rich,

Whereas, The Department of Health of the State of New York now supplies diphtheria antitoxin free of charge to families financially unable to procure the same, and could enlarge its facilities for the production of antitoxin at comparatively small cost,

Whereas, Various State Departments of Health, notably those of Massachusetts and Illinois, now supply diphtheria antitoxin free of charge to all their citizens, for curative and prophylactic purposes, and are satisfied that the interests of public health are well served thereby, Therefore,

Resolved, That the Homeopathic Medical Society of the State of New York believes that the public health of this State would be advanced if the State Department of Health were to furnish diphtheria antitoxin free of charge to all physicians desiring to use the same for curative or prophylactic purposes.

Resolved, That the Commissioner of Health of the State of New York be requested to take such steps as are necessary to provide such free distribution of diphtheria antitoxin. (Introduced by Dr. Hills Cole.)

MISCELLANEOUS BUSINESS.

RESIGNATION: The written resignation of Dr. George H. Smith, of Brooklyn, was, upon motion accepted.

COMMITTEES APPOINTED: The President appointed the following committees to act during this meeting: On Attendance, Drs. Nathaniel H. Ives, Walter G. Crump and Frank H. Wright. On Auditing of Bills, Drs. J. Ivimey Dowling, G. H. Jenkins, J. B. Garrison.

STANDING RESOLUTION ABOLISHED: The Standing Resolution, calling for an annual report from the Board of State Medical Examiners was, upon motion, abolished, in view of recent legislation affecting the same.

NOTICE OF AMENDMENTS: The Secretary gave notice of the following amendments to the By-laws (in view of State legislation), to be acted upon at the next annual meeting: Article IV., Section 2. Strike out the words "The chairman of the Committee on State Medical Examiners and." Article VI. Strike out the whole article and re-number succeeding articles accordingly. Article VII. Strike out lines relating to the nomination of State Medical Examiners and the nomination of a committee to nominate State Medical Examiners.

THE WIVES OF THE VISITING MEMBERS were entertained on a most liberal plan, beginning with a tea tendered by Mrs. W. W. Blackman, wife of the President of the Homeopathic Medical Society of the County of Kings, on Tuesday afternoon, and with a matinee party to the Hippodrome on Wednesday afternoon, which was most enjoyable to many of the ladies who had never visited this unique place of amusement. They proved to have a very pleasant day for their ride to Coney Island and luncheon at the Crescent Country Club on the shores of the bay. Between thirty-five and forty partook of the hospitality of the ladies of Brooklyn during the meeting.

THE CLINICS AT THE CUMBERLAND STREET HOSPITAL were well attended, many interesting medical cases being shown. A laparotomy was made, and a number of surgical cases, showing the successful methods which have been used in treating ordinary surgical cases, as met by the general practitioner. A number of interesting cases which were under treatment by the X-Ray and other electrical currents were also shown.

IN THE EXHIBIT ROOM there was a large display of specimens from the New York College, including over 150 X-Ray photographs. A large number of manufacturers and publishers had their wares on exhibition, and seemed pleased at the attention shown them by those in attendance.

THE BANQUET ON THURSDAY EVENING, tendered by the County Society to the State Society and their wives, was one of the most successful features of the meeting. Dr. W. W. Blackman, President of the Homeopathic Medical Society of the County of Kings, was toastmaster, and the following responded to toasts: Dr. H. D.

Schenck for "The State Society." Dr. E. Rodney Fiske on "A Retrospect." Dr. Stewart Close, on "Pioneers." Dr. Royal S. Copeland for "The American Institute." Dr. John E. Wilson, "The Influence of Homeopathy on General Medicine." Dr. De Witt G. Wilcox on "The Future Homeopathy." Dr. Charles E. Walton on "A Free Lance." (See Appendix for detailed report.)

KINGS COUNTY HOSPITALITY: "I wish to state here, as a matter of information, something which I find is not generally known—that the Homeopathic Medical Society of the County of Kings has paid all the expenses of this meeting. (Applause.) The State Society is not out one single cent for the hall or any other expense connected with this meeting, except what electricity the exhibitors use. I thought it due to the State Society to know this, as the County Society has been most liberal. They have tried in every way to forward each feature of this meeting, and as President, I want you to understand that they have given your officers the best possible support."—PRESIDENT SCHENCK.

SCIENTIFIC PROGRAM.

FIRST DAY.—MORNING SESSION.—10:45 O'CLOCK.

PÆDIATRICS.

HORACE G. KEITH, *Chairman.*

Spinal Curvature with Special Reference to Sciatica — George Parker Holden
Rheumatic Conditions of Childhood - - - Nathaniel H. Ives
Intestinal Obstruction - - - - Walter Gray Crump

OBSTETRICS.

CHARLES E. BIRCH, *Chairman.*

Artificial Dilatation of the Cervix—New Hydro-dynamic Dilating Bag of Pomeroy - - - George Hills Iler
Cystic Degeneration of the Chorionic Villi, with Report of a Case, with a Specimen — Loomis L. Danforth

---

FIRST DAY.—AFTERNOON SESSION.—2:15 O'CLOCK.

OPHTHALMOLOGY AND OTOLOGY.

GEORGE W. MCDOWELL, *Chairman.*

Eye Symptoms Suggestive of Complications in the Accessory Nasal Simuses - - - - J. Ivimey Dowling
The Clinical Significance of Ciliary Neuralgia, — Frederic G. Ritchie

LARYNGOLOGY AND RHINOLOGY.

LLEWELLYN J. SANDERS, *Chairman.*

The Sinuses as Routes for Infecting the Meninges and Mastoid - - - - - - - - - Ralph I. Lloyd
Hay Fever - - - - - - - - John B. Garrison
How to Blow the Nose - - - - - - Robert M. Jones
The Relation of the General Practitioner to the Specialist in Diseases of the Nose and Throat, John W. Le Seur

---

FIRST DAY.—EVENING SESSION.—8:00 O'CLOCK.

MATERIA MEDICA SYMPOSIUM.

RUDOLPH F. RABE, *Chairman.*

Reports and Discussion of Verification of Symptoms of Following Drugs:

1. Sulphur in infantile pneumonia - - - - B. L. B. Baylies
2. Bell. in clergyman's sore throat - - - B. L. B. Baylies
3. Rhus tox in neuralgia of pregnancy - - B. L. B. Baylies
4. Thuja in uterine fibroids - - - William W. Blackman
5. Hepar in uterine fibroids - - - William W. Blackman
6. Arsenicum in melancholia - - - William M. Butler
7. Arnica - - - - - - - - - D. E. S. Coleman
8. Willis Dewey
9. Melilotus in eye diseases - - - - J Ivimey Dowling
10. Arsenicum in surgical conditions - William H. Freeman
11. Staphysagria in chalazion - - - - John B. Garrison
12. Eleven successive cases of diphtheria - Joseph Hasbrouck
13. Agaracus in pneumonia - - - - George Hills Iler
14. Arsenicum in pityriasis rubra - - - William L. Love
15. Dioscor. in acute enteritis - - - Rudolph F. Rabe
16. Lachesis in jaundice - - - - - Nathaniel Robinson
17. Natrum Muriaticum in vernal conjunctivitis, Herbert D. Schenck
18. Lachesis in purpura hæmorrhagica - Walter B. Winchell
19. Lachesis in peliosis rheumatica - - Walter B. Winchell

SECOND DAY.—MORNING SESSION.—10:00 O'CLOCK.

MATERIA MEDICA (Continued).

Cantharis in Acute Nephritis and Endocarditis, Wallace McGeorge, Camden, N. J.
Medorrhinum - - - - - - - William Hazen Freeman
Comparison of Solanaceæ - - - - - - E. Wilton Brown

BUREAU OF PUBLIC HEALTH.

W. HERBERT NICKELSON, *Chairman.*

Clean Milk - - - - E. M. Santee, Washington, D. C.
The Family Physician and the Sanitary Officer - - Hills Cole
A Neglected Factor in Public Health - - - Harlan P. Cole

SECOND DAY.—AFTERNOON SESSION.—3:15 O'CLOCK.

BUREAU OF NEUROLOGY.

MAURICE C. ASHLEY, *Chairman.*

General Paresis and the Family Physician, Robert C. Woodman
Two Cases of General Paresis of Long Duration, Roy E. Mitchell
The General Practitioner and his Insane Patients, Reeve Turner
Homeopathic Treatment of Insanity - William Morris Butler

CLINICAL MEDICINE.

HOWARD P. DEADY, *Chairman.*

Medical Examining Boards, Past, Present and Future, William S. Searle
Recent Aids in the Diagnosis of Tuberculosis, George F. Laidlaw

---

THIRD DAY.—MORNING SESSION.—10:00 O'CLOCK.

BUREAU OF SURGERY.

JOSEPH H. FOBES, *Chairman.*

Pyæmia Following Vaccination - - - Orando S. Ritch
The Value of the Leucocyte Count in Surgical Conditions - - - - - - - - - - - Warren C. Daly
Popular Errors Regarding Nephroptosis - Sidney F. Wilcox
Hyoscin, Morphin and Cactin Anæsthesia, Charles E. Walton
Surgery and the Public - - - - - - William F. Honan

BUREAU OF GYNÆCOLOGY.

E. RODNEY FISKE, *Chairman.*

Cancer - - - - - - - - William J. Shrewsbury
Ultimate Results in the Operative Treatment of Carcinoma of the Pelvic Organs - - - De Witt G. Wilcox

---

THIRD DAY.—AFTERNOON SESSION.—2:00 O'CLOCK.

CLINICS.

At the Cumberland Street Hospital.

REPORT

OF THE

BUREAU OF PÆDIATRICS.

"Spinal Curvature with Special Reference to Sciatica," GEORGE PARKER HOLDEN.
"Rheumatic Conditions of Childhood," - - - - NATHANIEL H. IVES.
"Intestinal Obstruction," - - - - - - WALTER GRAY CRUMP.

SPINAL CURVATURE, WITH SPECIAL REFERENCE TO NEBEL'S SUSPENSION-FRAME AND SCIATICA.

GEORGE PARKER HOLDEN, M. D.,
YONKERS, N. Y.

Cases of spinal curvature coming under the care of the general practitioner often belong in the category of things destined to bother him considerably. Having been bothered this way to some extent, it is my simple intention to summarize, crudely rather than minutely, a few points that have appealed to me as being both pertinent and practical, and I do this with due apologies to any orthopedists present.

It may be said at the outset that curvatures are due, principally, either to localized diseases or to rachitic, paralytic, or postural or occupation factors. It may also be stated, by way of preliminary, that an exaggeration of the normal anterior or posterior curves is not to be considered pathological until so pronounced that the bend in one section is not wholly compensated for by compensating curvatures in other regions; this failure of compensation being then the prominent disturbing factor. For instance, the normal dorsal curve, a kyphosis, when exaggerated, must be compensated for by an exaggeration of the normal lordosis of the cervical or lumbar sections. Lateral curvature, it will be remembered, is termed a scoliosis, and is generally complicated by some rotation, or twisting, of the column.

By far the greater number of cases of curved spine occur during infancy or the first decade of life, and tuberculous, or Potts' disease (spondylitis tuberculosa) is the most common inflammatory process. Rachitic defects and those due to faulty attitude, whether occupational or not, make up the bulk of the other cases.

In examining the patient, principal points to look for are deviations from the normal antero-posterior, or sagittal, curves of the column, which frequently obtain as angular protuberances or depressions; any lateral inclination; diminution of normal flexibility, due either to inflammatory deposits or instinctive or spasmodic muscular rigidity, or both; and localized tenderness, particularly upon pressure or light tapping over the spinous processes, and the bringing into action or over-exerting of the weight-bearing function of the vertebral bodies. The latter is safely tested by slight sudden pressure upon the head or shoulders.

Flexibility or its deficiency is tested by having the patient lean forward over the back of a chair, or other convenient object, and by placing the palm of the hand over suspected prominences, and noting if there is individual movement of the vertebræ upon flexion and extension. With the column sharply flexed, marks placed upon the spinal points will reveal any lateral deviation.

Considering, first, the treatment of the class of cases last noted, to wit, postural or occupational curvatures, generally a scoliosis or complicated thereby, it may be stated broadly that general constitutional treatment by baths, nutritive diet, fresh air, massage, and appropriate gymnastics should have the prior consideration, jackets to be avoided if possible, and in particular it should be seen that any form of shoulder braces used only in the intervals of the treatment stated, should not be of any "suspender" type to depress the shoulders while drawing them back. Suspension exercises are valuable and, to repeat, exercises are the most important factor in treating scoliosis in any stage. For details of ingenious movements, with dumb-bells, rods, etc., recumbent and otherwise, reference must be had to the voluminous literature of the subject.

Another important point in considering lateral curvature is the causative factor of the discrepancy, whether congenital or acquired, in the length of the legs. Always measure the leg-lengths in these cases, and if a marked difference be noted, a prominent factor in any remedial treatment is self-evident.

Harking back, now, to the consideration of cases of tubercular spine and of rachitic weakness, it should be very evident that support or partial immobilization should receive first consideration. As the intent of this support is both to hold the spine in as normal a position as possible, keeping up at the same time a degree of extension to relieve pressure symptoms, and to prevent further increase of deformity, it is apparent that the jacket or other device selected must be applied with the exaggerated conditions reduced nearly as may be to the normal contour. And this is where the different forms of suspension apparatus, slings, frames, etc., come in. Particularly in dealing with children, and especially as a jacket may have to be renewed several times, the least terrifying and fatiguing device is self-commendatory.

Some months ago, having occasion to apply a plaster jacket in a

case of lumbar kyphosis, the attention of the writer was attracted to a suspension frame made of iron tubing, with transverse straps of canvas or leather passing under the patient at the sternum, trochanters, and below the knees, as used by Nebel in his Breslau clinic. This recommended itself because of the not particularly unpleasant suggestion of a hammock or bed upon which the patient lies, and consequent feeling of security, and for the possibility of substituting a simple wooden arrangement that could be quickly put together by any carpenter. I had one made, somewhat more carefully than this crude miniature model, and found it very convenient.

NEBEL'S SUSPENSION FRAME.

In cases where the trouble is in the higher dorsal or cervical sections of the column, and where more head extension is desired, the inclination of the bed-frame may be made very sharp, almost to upright, by raising the head end of the frame. For lower dorsal or lumbar cases, where the sagging due to mid-body weight is the chief factor in producing the required extension, the frame is brought nearer to the horizontal. For the Glisson's head-sling I substituted a Barton bandage, and the separate three transverse and one longitudinal bands or straps of Nebel's apparatus, with the four adjustments, I modified by using a continuous, single, canvas belt about four inches wide, with a single tension adjustment, as here shown.

The patient assists in supporting himself and relieving the strain upon the head-sling, by grasping the upper cross-bar with his hands.

As to the supporting device itself, the plaster cast, or jacket, for combination of simplicity, economy and effectiveness, will be selected nine times out of ten by the general practitioner; at any rate, for the beginning of this supporting treatment. And there is no good reason why this should not be a removable jacket instead of the much more uncomfortable cast.

If the following points be observed, any physician with slight mechanical dexterity should be able to apply such a jacket.

It need not average much over one-eighth inch in thickness, and the plaster must be well rubbed in as each layer is applied. The bandage can be re-duplicated where most strength is needed, as along the spine and axillary line, to bring it up to nearly one-fourth inch. The bandages are applied over any seamless, tight-fitting, preferably woolen, undershirt, the hospital supply houses furnishing a tubular affair, without armholes, especially for the purpose. In lieu of this, what is known to the dry goods trade as a Swiss undervest is the best article. The jacket should reach well up under the arms, highest in the back, and down over the trachanters, the lower edge being cut out at the thighs to permit of the sitting posture.

The patient should remain perfectly quiet until the plaster has set sufficient to permit of removal without breaking. This takes generally about fifteen or twenty minutes, and a good plan to support it while thus setting is by use of light (basswood) splints placed up and down, and held around the jacket by an unbleached muslin bandage. It is not a bad idea to incorporate four pieces of these splints within the jacket itself, between the layers of plaster-bandage, one at either side of the spines and one in each axillary line. They are first made more pliable by soaking in hot water.

In making a jacket, a strip of tin is placed along the front of the thorax, next the woolen shirt, the whole length of the intended cast, and when the plaster has set sufficiently, and just previously to removal, the cast is cut down the front with a knife, against the tin. It can now be sprung apart sufficiently without fracture, to remove it sidewise by twisting it around.

The edges are now trimmed out at the axillæ, and at the bottom in front for the thighs, and after pressing it together in front, hold it so with a roller bandage and leave it twelve hours over a radiator or the kitchen stove to bake hard.

When thoroughly dry, it is ready to finish and put on the patient for use. Put on the skin-fitting shirt again, as when applying the plaster-bandages, and sew to it pads of cotton wadding, or preferably felt, over the prominences of the spines, trochanters, the more prominent ribs at the sides of thorax in thin subjects, and along the top and bottom edges of the jacket. Having already applied one coat of shellac to inside of jacket to render it non-absorbent, after it was thoroughly hard and dry, now apply a second, and put the jacket on over the padded shirt while this second coat is still wet, care

being taken during the placing of pads and sticking fast the lining of jacket that the shirt is held taut. The edges of the shirt are now folded over the outside of jacket and sewn together, completely covering in the plaster.

Strips of leather in which a cobbler has punched some shoe-lace hooks are now sewed one along either front edge of the jacket, a shoemaker's awl being used to pierce the plaster for the stitches. Two laces are used for fastening, both starting at the middle in front, one being tied at the upper and one at the lower edge.

It is preferable to have the patient assume the position on the suspension-frame maintained when molding the jacket, when the completed affair is first applied for wearing.

Regarding the matter of differential diagnosis, it must not be forgotten that children with hip-joint disease manifest several of the same characteristics as those with inflammatory spinal affection—notably the peculiar mode of stooping straight down, with back held rigid, instead of bending forward, and of climbing up with the hands on the thighs from a stooping position. In the contraction of the hip due to psoas abscess following Pott's disease, only extension is affected, while in hip disease all motion is limited. Also, there is in hip disease an actual shortening of the leg and exaggerated height of the trachanter.

Inflammatory affections of the vertebræ, other than Pott's, are acute osteomyelitis, spondylarthritis, syphilis of the spine, actinomycosis, spondylitis deformans, and malignant tumors of the spine.

The kyphosis, which it generally is, of inflammatory diseases producing necrotic conditions like Potts' or tumors, is angular rather than crescentic, and such patients are often relieved by diminution of pressure, as from lying down. They will be apt to feel better in the morning, and in sitting, prefer chairs with high arms on which they rest their elbows and draw themselves up. This is more characteristic in Potts' than in malignant growth, which is painful, independent of pressure in the long axis of column.

Acute osteomyelitis has only lately been recognized, but it is a disease of the growing years. The specific organisms are the pus cocci, staphlycoccus aureus and albus. The lumbar region is generally the part involved, and any portion of the individual vertebra may be attacked. It follows an acute stormy course. Tuberculosis is of a chronic tendency and almost always attacks the body of a vertebra.

Spondylarthritis is the rare condition of inflammation of the lateral joints, and when of tubercular origin generally occurs in the cervical vertebræ, accompanied by severe neuralgic pains, rigidity of the neck, and sub-occipital swelling due to infiltration. Later, the head assumes a typical position with the chin drawn down upon the sternum.

Syphilis of the spine is also very rare, and is practically never seen in children as a cause of curvature. Belonging to the tertiary stage of the disease, it is seen in syphilitic adults. Diagnostic conclusions

otherwise must be drawn from the history of the case and effect of anti-syphilitic treatment, as the clinical picture may very closely simulate tuberculosis. But iodide of potash must be given very guardedly, as it is put down in the books as a disastrous remedy for tuberculous patients.

Actinomycosis, a disease produced by the ray fungi, has very exceptionally caused necrotic changes in the spine, but practically is a disease of little surgical interest. Infection occurs, as a rule, through the esophagus, lungs, or intestines, and absolute diagnosis is made only by finding the typical ray fungi, which usually occurs long before the spine is affected. The literature states that the region involved may be extremely sensitive upon pressure or exerting the weight-bearing function, but that an actinomycotic actual kyphosis has never been reported.

Spondylitis deformans, like rheumatism of other parts, may be acute at first, but has a strong tendency to gradually become chronic. Those affected are, as a rule, from twenty-five to forty years old, or well advanced in life. Only most exceptionally is it a disease of childhood. Pain generally commences in the small of the back, and the spine gradually becomes rigid. The lumbar and lower half of the dorsal vertebræ are more prone to be the parts affected, and the trouble is more liable to extend up than down. The whole column may become immovable, generally in kyphosis, which is often seen in the upper part, though there may be kyphosis of the lumbar section; and sometimes scoliosis may be detected.

Tumors of the spine are practically all malignant, occurring in adult life, and may produce conditions impossible to diagnose from tubercular infiltration and necrosis. The previous occurrence of a primary malignant growth, and aggravation rather than relief from extension, are diagnostic clues.

In conclusion, the physician should not overlook a point that the writer had recently impressed upon his mind through an interesting clinical experience—the point that it is not uncommon to have marked curvature of the spine with sciatica. Attention was first called to this subject by Gussenbauer as recently as 1878, who gave it the name of neuro-muscular scoliosis. Kocher calls it ischias scoliotica. There is also a kyphosis of the lumbar section of the spine in addition to the lateral deviation.

Because of muscular spasm caused by the pain, and of attitudes taken by the patient for relief of pain, a crooked back is produced during the long course of this disease. While cases of sciatica are quite unknown in childhood, yet this is a very interesting point concerning any discussion of curved spine. Treatment should be directed both to the original sciatica, and also to the back by braces, jacket, suspension and other exercises. Forms of rowing apparatus, in the use of which the nerve is stretched at the same time the spine is straightened, have proven especially helpful.

It is an interesting query, if a patient contracting a curved spine from a sciatica might not months later be found suffering from pains

simulating his sciatica, but now due entirely to reflex disturbances arising from abnormal, unequalized pressure due to the malposition of the bones of his back. I have such a case in mind so diagnosed, but a prominent orthopedist later called it (though not very positively, as I understand), rheumatic spine. So far is I have been able to keep track of the case since this occurred some months ago, the gradual, if slight improvement, would seem to give the first diagnosis as good a claim to accuracy as the second, especially in view of the following points: Patient was better of his pain in mornings after a night's recumbency, pressure upon the lumbar kyphosis (there was some scoliosis also) caused no discomfort at point applied, but did cause pain high up in the hip over the sciatic nerve; there was absolutely no history of gonorrhœa; the vertebræ involved in the kyphosis seemed individually to move on flexion; did not seem to be rigid, and relief was experienced by exercises of over-extension and the wearing of a plaster jacket, and later a brace.

DISCUSSION.

GEORGE PARKER HOLDEN (showing model): This is slightly out of proportion. It ought to be a little wider with reference to the length. Otherwise, it gives you a pretty fair idea of the apparatus, although it has been put together very hurriedly. His is made of iron tubing and fastened together in this way, and is quite an expensive affair. A full size frame of this kind, of wood, was put together by a carpenter in half a day, at an expense of only six or seven dollars. In Navel's apparatus there are three bands which cross at the sternum, the trochanters and below the knees, and he has some straps here with a buckle on each strap and a longitudinal strap fastened to these others, and takes up the slack with these buckles. In making up this wooden frame, the full width of this band was four inches, and it was made of a continuous piece, and these little wire arrangements in the original were like links of a chain, about seven inches wide, which any blacksmith could make at very little expense, and this bandage was brought around the patient's head and fastened here (indicating). This cord is, of course, smoothed up. The patient hangs his head through here and grasps this cross-bar at this place (indicating). By pulling up on this adjustment down here, you can tighten up this bandage all the way through. This brace here, this little cross-bar, by running this down through it gives you room to work. In cases where the curvature is in the upper dorsal or cervical portion, where you want to get considerable head extension, you can tip this up pretty nearly to upright. Fastening it in that position, you get the patient practically hanging by the head. By adjusting the frame and slacking on these (indicating), you can get pretty nearly any position of the spine you want. These little pegs—you can have a series of holes and move these, and hold these cross-bands in any position you want, according to

the size of the patient and the position in which they would come on the patient's body. The patient assists in supporting himself and relieving the head strain by grasping the upper cross-bar with his hands.

NATHANIEL ROBINSON: It would be impossible to fully appreciate the advantages of the Navel frame in the application of plaster Paris dressings unless one has had some experience with the old style Sayres extension apparatus, where the patient is suspended for half an hour, fainting oftentimes, twisting and turning so that the jacket gets a crack and is useless, and we have to try again next day or wait a few days. This apparatus certainly is a great advantage. Having had the experience I have described, I have entirely discarded the Sayres apparatus, and can most heartily endorse the present one. I think the Doctor deserves great credit for his ingenuity in arranging this more simple apparatus.

In speaking of the relation of sciatica to curvature of the spine, it certainly is a very rare condition, and is due, in a large majority of cases, to the postural attitudes assumed by the patient in seeking relief from pain and the inability to bear weight upon the affected side. In those cases the curvature is either a concavity on the side of the affected limb or a convexity on the side of the affected limb. Both cases occur. But it certainly is a very rare condition, and is due mostly to the muscular spasms resulting. The convex is principally in the lumbar-dorsal region and is a severe complication, because when you apply a jacket to a case of that sort you make pressure which is very badly borne. I never have heard of a case occurring in a young child, and I would like to ask the Doctor the age of this patient that he had. The methods given for the construction and the working of a jacket of this sort certainly simplify matters very much indeed, and it certainly is a very great help to the orthopedic surgeon. (Applause.)

GEORGE PARKER HOLDEN: That case that was diagnosed sciatica was an adult case, and I simply spoke of it as a general case of curvature. I never heard of a case of sciatica in a child.

HILLS COLE: In the Hospital for Ruptured and Crippled at 42d Street and Lexington Avenue, New York, about a year ago, I had the pleasure of seeing a case that had been going regularly to the hospital for a matter of two years to have a plaster jacket applied for spinal curvature, without very much improvement, according to the history of the case. When the child lay down on some such apparatus of that character that they had, and the plaster jacket was applied, you got a pretty straight spine, but directly the child stood on its feet, the whole of the trouble, or a good deal of it, was produced. Now, the Doctor has mentioned the fact that it is always well to measure the length of the legs. If a tape measure had been applied to that case you would have had a perfectly equal length of legs. There was an anatomical correctness or equality, but there was a physiological inequality. There was a weakness of the muscles of one part, allowing a depression of the ankle on that side,

Consequently, with the potation or prolation of the foot on that side that side had dropped a little, and with the dropping there had come a tilting of the pelvis, and with the tilting of the pelvis a tilting of the spine and shoulders; and no matter how many plaster jackets are applied, you cannot cure a spine that is deviated owing to such a condition as that. That is, if there is any question that the trouble arises below the pelvis, you not only want a tape measure—you have to have that—but you also want to see the patient stand up. You will find that a good many spinal curvatures, especially in young girls, can be cured immediately by putting under one leg a magazine, or something like that. I have in mind a case now in Hartford, Conn., that came under our care; had been treated for a number of years with a spinal plaster jacket. The mother of the patient stood by the window, and we let the full light on the back of the patient, a boy of sixteen or seventeen, as he was stripped. Then we took a magazine off the table and put it under one foot, the ankle of which was evidently drooping, and immediately the shoulders squared and the spine straightened up. The woman looked at the thing from all sides, twisted her head, and said, "Why, he hasn't any curvature now;" and that was the self-evident fact. You have to look after the physiological shortening just as much as the anatomical shortening. Instead of using plaster jackets, we are using very largely now just a heavy canvas jacket with reinforcements of steel bands down the back, each side of the spine, with a part of the band coming over the shoulder, and are able to obtain a good deal of correction of the deviation by the degree with which you pull one of these shoulder straps. If you pull one more than the other, you make quite a difference in the spine. We find that works equally well with a plaster jacket so far.

We had an interesting case sent over by a New Jersey physician about a year ago, a boy who had a marked kyphosis. One of these canvas jackets was applied. The boy is nineteen or twenty years old, and it would not seem as if he could be expected to grow a great deal after that age, but we have added four inches to his stature, and I think that has very largely come about because we have been able to reduce the swelling around the curved spine.

GEORGE PARKER HOLDEN: I appreciate the fact that a physiological shortening due to muscular weakness is quite as important to be taken into account as a measuring from the bony landmarks, and of course I was speaking of this case from the standpoint of the general practitioner. I think I am right in the assertion that nine times out of ten we should take all things into consideration. If one finds relief from this more expensive apparatus later on, of course it is more elegant and more comfortable.

RHEUMATIC CONDITIONS IN CHILDHOOD.

NATHANIEL H. IVES, M. D.,
MOUNT VERNON, N. Y.

Of recent years it has become known that rheumatism is the causal factor of many sets of symptoms which may occur in many parts of the body, and involve almost any organ, and these sets of symptoms are given various names, depending upon their location and the organs involved.

Thus, we are called to treat what we may choose to designate as iritis, tonsilitis, chorea, endocarditis, pericarditis, or myocarditis —skin lesions such as erythematous rashes and pupura—perhaps pleurisy, meningtitis, neuritis or even growing pains. So we see that rheumatism in childhood is not always manifested as an arthritis, but by a great variety of symptoms which are not always complications, but rather forms of the disease itself; and the recognition of this fact is essential, if we would treat them understandingly.

The exact cause of rheumatism is still unknown, but there are numerous theories. The one generally accepted and most popular is that it is due to chemical changes from a defective assimilation, resulting in the formation of abnormal toxic products. Of these, lactic acid seems to be the most frequently mentioned.

Heredity plays an important part a rheumatic family history being frequent, while unhygienic surroundings or exposure to cold and damp is a most prolific cause.

In children over ten years of age, the symptoms are apt to resemble the adult form, while in younger children they are so varied that a diagnosis is often difficult, and frequently other diseases are wrongly called rheumatism. Particularly is this true of scurvy.

The adult form we all know well, with its sudden onset of high fever, inflamed joints, sweat and perhaps delirium. Then be watchful for complications—most frequently of the heart. In this my experience has been most unfortunate. I can recall many cases where the little ones have been destined to go through life with a leaky valve, notwithstanding the fact that from the very beginning I carefully watched the heart, and adopted every safeguard at my command.

Endocarditis is the most frequent variety, and its development may be so insidious that without a daily stethoscopic examination, it is frequently overlooked. It is, however, usually present, and should always be sought.

I bring to mind one case in my practice which I consider rather unique, where the inflamed endocardium preceded the arthritic development by several days. This was a young girl, some ten or twelve years of age, whose only symptom was a fever, and in hunting for

its cause I discovered a slight murmur. Two days later the arthritis appeared, and the diagnosis was clear.

As for treatment, do not wait for the classical symptoms of rise of temperature, weak pulse, precordial distress and dyspnœa, because there is no possible cure for organic heart disease. Our one great hope is its prevention, and as it means so much to the future of the child, look early for endocarditis, not only in your cases of articular rheumatism, but in chorea, myalgia, pleurisy and severe tonsillitis. I have now under treatment another rather unique case, illustrating this point—an adult who, two months ago, had follicular tonsilitis, and as a sequel has developed an endocarditis, being now confined to her bed for six weeks. She is flat on her back, with a pulse of one hundred and twenty.

When you find the patient threatened by endocarditis, put him to bed at once. Any exertion will certainly increase the heart's action, which of necessity must add to the inflammatory process. The ice-bag has been of wonderful service in my hands. In severe cases I have applied it every other hour; and in one desperate case the patient begged piteously for its continuous application as the only means of relief.

For remedies: In the early stages, aconite, belladonna and veratrum viride. Later on, bryonia, spigelia and colchicine are good. I am an enthusiast for salicylate of soda and the various salicyl derivations, of which I shall speak later.

Be very slow in letting the patient get around. Keep him in bed for at least a month, and then restrict his exercise for many weeks. Otherwise, dilatation with dropsy, palpitation, short breath, irregular pulse and cough are apt to result. All children who have had endocarditis should be protected as much as possible from subsequent attacks of rheumatism.

Pericarditis is another, though not so frequent complication. This condition is apt to prove fatal. Again, the ice-bag has been my anodyne, with the same remedies as for endocarditis, plus apis, cantharis and infusion of digitalis when fluid was present.

Chorea is another disease of childhood which is very frequently a complication or sequel of rheumatism. In looking over the statistics of various authors on this subject, I found a wide variance of figures—some claiming a rheumatic history in only ten to fifteen per cent. of their cases, while Holt, for instance, considers rheumatism responsible for fifty to sixty per cent.

In the few cases of chorea which have come under my care, they all gave a rheumatic history. One case I recall had first scarlet fever, then rheumatism as a complication, and finally a severe chorea.

While the prognosis of chorea is usually good, it has been my misfortune during the past year to have one patient die. The motor manifestations became intense, universal and constant, preventing sleep, and soon developing into a wild maniacal delirium, causing death from exhaustion. This was a strong, robust, twelve-year-old girl whose attack started as a mild rheumatic fever.

Choreic children, if the case is at all severe, should be put to bed. Cases of moderate severity should be taken from school and be kept out of doors, but all physical exercise restricted. Their diet should contain a preponderance of fat, such as cod-liver oil, milk and eggs.

For remedies, we always think of such drugs as belladonna, hyoscyamus and rhus, although I have always followed Goodno's advice, and administered agaricin 2x in all cases not presenting strong indications for some other remedy.

Fowler's solution of arsenic is the Old School's routine treatment and should not be overlooked.

Several paragraphs back I spoke of scarlet fever, rheumatism and chorea all in one case. It may be worth while relating, that in the spring of 1904 we had in our city a scarlet-fever epidemic due to infected milk delivered by one of our largest milk concerns; and during that period I saw over twenty cases of which fully one-half developed rheumatism as a complication or a sequel.

Tonsilitis and pharyngitis come next on my list of possible rheumatic manifestations. I have seen many cases of rheumatism begin as one of the above. Frequent attacks of tonsilitis in a child should always make one think of a rheumatic diatheses. If the attack is severe, the heart should always be examined, and if found to be involved, it shows the nature of the infection. Many stubborn cases of hemicrania and gastralgia would be quickly cured if their rheumatic origin were known. Skin lesions also are sometimes found; various forms of erythema, urticaria and pupura.

The diagnosis of rheumatism in infants and children is a big subject, and not an easy matter. The fact that it is a rare occurrence under two years of age will help us greatly to differentiate it from scurvy. We may safely say that an infant with pain in the legs, without fever, and being fed on an artificial diet, has scurvy and not rheumatism. A few days' feeding of orange juice and beef juice will clear up the diagnosis.

Rickets in its early stages may easily be called rheumatism, although the sweating head, great restlessness at night, delayed dentition and open fontanel should prevent such a mistake.

In making our diagnosis of rheumatism, Holt says we should consider "(1) The family history, because in early life heredity is such an important etiological factor. (2) The previous history of the patient, not only as regards articular pains and swelling, the indefinite wandering pains of damp weather, and the so-called growing pains, but also the previous existence of choreo, tonsilitis, torticollis or erythemia. (3) The thorough examination of the heart for endocarditis or pericarditis; and always ascertain the temperature."

In doubtful cases, the presence of a slight temperature may help us to distinguish from trauma.

This brings me down to the treatment both curative and preventive. For these little ones with a rheumatic inheritance much can be done in the way of prophylaxis. We *must* take the time and

trouble to see that the parents of little Johnny Brown or Mary Smith, who has had three or four attacks of tonsilitis during the winter, are made to grasp their full significance, and to understand the danger of these repeated occurrences.

Rheumatic children should wear flannel undergarments the entire year, should avoid getting wet feet and exposure to damp weather. The tendency to a recurrence is very strong, and nothing for its prevention should be overlooked. Otherwise it is only a question of time when repeated attacks will impair the usefulness of the heart.

The diet is of considerable importance, although apparently a matter of considerable difference of opinion. Holt recommends nitrogenous food and a restriction of starches. When we remember, however, the strong tendency to anæmia, a highly nourishing diet seems imperative.

Mild cases must be watched thoroughly, and *not* considered as of little importance.

During the acute attack, absolute rest must be enforced to save the heart. It is better to keep the patient in bed a few days too long than to let him get up too soon. The diet at this time should be wholly milk with vichy or seltzer. The affected joints should be done up in absorbent cotton, and I frequently apply oil of wintergreen with apparent relief of pain. The bowels should be moved every day, water (preferably alkaline) being given freely.

Internally, besides our regular indicated remedies, I am very prone to use the salicylates. I prefer the salicylate of strontium, used in the same dose as the salicylate of soda; its advantage being that the strontium is an inert, non-irritating substance, which will not disturb the digestion.

Aspirin has been my best remedy. It rarely fails to relieve pain and is used in doses of one to five grains every three hours.

When giving any of the salicyl derivations, I always give an equal amount of bicarbonate of soda, and have thus far, seen no evil effect upon the stomach.

Colchicine is also a wonderful remedy. I believe Goodno considers it almost a specific while aconite, bryonia, rhus tox, pulsatille are useful according to indications.

A strong field for the Homeopathic remedy, a field where it will accomplish much, and yet is so frequently ignored, is the constitutional remedy, such as the calcarias, lycopodium, kali iodide and sulphur.

These remedies carefully selected, and prescribed to antidote the rheumatic diatheses, will prevent many attacks and lessen the severity of others.

And now, in closing, let me say that the main object of this paper is to impress upon the physician that, when treating chorea, tonsilitis, nervous symptoms, anæmia or growing pains, do not forget their possible rheumatic origin and keep a careful watch upon the heart.

DISCUSSION.

REEVE B. HOWLAND: I would like to speak, in connection with this case, of one I had which presented symptoms of cerebro-spinal meningitis with active delirium for nearly a week, followed by coma, arthrochondritis, joint symptoms, the temperature ranging from 103 to 106, a damaged heart, and finally recovered. For three days we had the joint symptoms, and we had an active and most furious delirium for forty-eight hours, which only responded to some of the bromides. Then that was followed by coma. The kidneys at that time shut down so that we had a very scanty urination, and about that time began to get the muscular contraction at the back; so that for nearly three weeks that case was unconscious. That was a case of a girl of thirteen, and since then I have had, within the last year, three cases in children over eight years of age, between that and fourteen, in which the condition began as acute tonsilitis, and all of those cases developed joint symptoms, and all of them developed endocarditis.

HORACE G. KEITH: Before Dr. Ives closes the discussion I would like to speak of a case I had last winter, and which Dr. St. Clair Smith saw with me in consultation, an extreme case of pericardial effusion, the greatest effusion, Dr. Smith said, he had ever seen in his practice; so great that it not only pushed the heart aside, but the dullness came way over and blended with the liver dullness, so that you could not tell where the liver stopped and where the pericardial effusion began—tremendous. It was so extreme, and the distress to the child was so terrific in breathing, that the question of tapping the pericardium was brought up, but was put off from day to day, and was not finally necessary, as she finally commenced to improve, and after months in bed, with quiet and treatment, principally with bryonia, she pulled out.

INTESTINAL OBSTRUCTION.

WALTER GRAY CRUMP, M. D.,
NEW YORK CITY.

The general practitioner has to deal with no class of cases that require greater exercise of judgment or demand of him more decided and prompt action, if they are to recover, than do these cases of intestinal obstruction.

The great majority of those afflicted with this condition are attacked while in vigorous health, and a sudden illness coming on at such a time often causes not a few physicians to postpone radical

action, trusting that nature's processes or the mechanical measures they have instituted may remove the obstruction and restore the sufferer to health.

Then, again, there is the great difficulty of early diagnosis, for in its incipiency this condition simulates most accurately many of the lesser ills, which a few doses of medicine or a few hours will entirely dispel. Here it is that a good homeopathic physician has an undoubted advantage over his brothers of the Dominant School, for it is their almost invariable practice when called to a case suffering acute abdominal pain, to give morphine at once, and this masking of the symptoms which develops after the administration of the narcotic is often so deceptive that the patient thus relieved is thought to be doing nicely, when all the while the condition is fast becoming more and more serious and is hurrying unappreciatedly on to a fatal issue.

The too zealous Homeopathist, who with his ardor for the action of the similimum, often does not appreciate when his case has passed beyond the pale for action of the so-called indicated remedy, into that condition which requires mechanical or other means of cure, is with the morphine users also in a class that spell "Danger," in these conditions where delay is disastrous.

The great mortality of this condition, which statistics place all the way from 50 to 80 per cent., is the mortality of delay. The condition early appreciated and surgical methods promptly instituted should readily respond to such treatment with a percentage of recovery little less than that of the ordinary laparotomy.

Experience is our greatest teacher, and we generally learn far more from our failures than our successes. Statistics are usually more important to the surgeon who makes them than to anyone else. During the hours after the establishment of complete occlusion of the intestinal tract, what is it that is taking place to bring about in the system this tissue disintegration? And this lack of resistance, which makes this so grave a condition; surely, it is not the simple mechanical obstruction? No, but the absorption into the system of the putrid septic contents of the bowel above the point of occlusion, by the congested, inflamed, and often ulcerated mucous membrane.

Too many of us in reaction from contemplation of the harm which we constantly see taking place because of the ill-advised action of the thousand and one cathartics which flood the market, swing with the pendulum too far in the other direction, and come to regard the bowel contents as simply inactive waste products of digestion, forgetting that there has been added many putrid excretions and poisonous substances by the multitude of glands connected with the alimentary canal.

It is very evident to all logically-thinking physicians that the auto-infection idea which has fathered the use of cathartics has been greatly overestimated, for there is no doubt but that the healthy bowel may tolerate for many, many days, its contents without harm;

but let that bowel become congested or inflamed, or the contents be transferred by reverse peristalsis from the lower intestinal tract into the duodenum or stomach, and you soon have putrescence and absorption of those poisonous products, with most profound toxemeas.

There is no doubt but that the large intestine which is essentially a dryer and absorber of the fluids, also permits all kinds of bacterial degenerations, but in its healthy state it is also possessed of inherent qualities preventing poisonous absorption.

These preliminary considerations of some of the facts bearing on this subject, bring us to a point where we can appreciate the more fully some of the phenomena of intestinal obstruction, and the duties and procedures required of the physician who has such a case to deal with.

Bowel occlusion is a condition which has been definitely known since the time of the earliest writers on medicine; but with all the advances in the art of healing the sick, the mortality in this class of cases is very little improved; and this is so, not because our surgeons have failed to advance in their understanding of how to handle this condition, but because these cases are not early enough diagnosed by the general practitioner, or if understood early, their seriousness has not been sufficiently impressed upon him during his college training, so that he has to pass through several terrible calamities along this line before he is brought face to face with the realization of his duties as medical adviser when this class of conditions arise.

The causes of this condition are many; acute indigestion, lack of abdominal tone, etc., etc.; but we find them arranging themselves into several distinct classes of obstruction, intussusception accounting for thirty per cent. of all cases, and as it occurs mostly in children, explains why this paper is presented under this Bureau. Of the other causes, internal strangulation, volvulus, congenital occlusion, acquired strictures, fœcal impaction, foreign bodies (including gall stones), post-operative paralysis, especially following suppurative appendicitis, account for nearly all of the cases.

(Foreign bodies are especially interesting to me, because my small son of six swallowed a few weeks ago a large plum pit, and for some time I had visions of intestinal obstruction, and was amazed at how difficult it is to ascertain from medical literature the diameters of the illiocecal orifice at the various ages and also how scattering and unclassified as to size, is the record of foreign bodies in the intestine.)

Whichever form of obstruction is present, there are certain symptoms common to all. Let us consider them for a few moments and try to figure out some rules that will guide us in diagnosis and point to the time when surgical interference is indicated.

The first symptom is usually sudden abdominal pain, often diffused, but generally aggravated in the region of the navel, followed soon by nausea and vomiting. There is inability to pass gas or

feces after that part of the canal below the obstruction has been emptied.

We get a gradually increasing temperature, but a more rapidly increasing pulse rate. Prostration early develops and soon becomes profound. Hiccough adds to the patient's distress. Abdominal distention soon supervenes, and dyspenœa becomes more and more marked. If several of this group of symptoms persist after twenty-four hours of medication, and show no signs of abating, an exploratory incision, at least, should be no longer delayed. Fecal vomiting should not be waited for, as it often does not occur, especially if the occlusion is high up.

Should vomiting at any time become stercoraceous, or develop even a fœcal odor, operative measures should be instituted with all possible haste. Parks Triad intense abdominal pain, collapse, with rigidity of abdominal walls should cause us to waste very little time speculating as to the lesion.

An operation will very often be delayed for fear of adverse criticism should the patient not recover after surgical interference, and again, there is the fear that the abdomen might be opened and nothing be found requiring an operation; but when one has to do with the making of decisions where human lives are at stake, he must school himself to have the courage of his convictions, and in these perplexing cases should never hesitate to share with a brother practitioner these great responsibilities. He should ever bear in mind the facts that while it is required of him that he shall exercise ordinary skill, he is not held to be infallible, and should death occur after operation, it invariably occurs, not because of the operation, but because it had been too long delayed. This delay is often brought about by inability to get the consent of the patient, or family, for such a procedure.

An operation decided upon should be proceeded with with deliberate haste. Before proceeding, probably the most important preliminary is the washing out of the stomach with hot saline solution; for almost invariably this is distended with gas and putrid contents, which not only add further poisoning to the system, but, with the relaxation which anæsthesia promotes, often causes the contents to be regurgitated into the upper air passages and inspired, and the patient, if not drowned in his own vomit, may subsequently develop inspiration pneumonia.

The stomach should be washed out thoroughly and frequently, as soon as any vomited matter presents a putrid odor. Insuflation in cases of invagination of the large intestinal tube or rectum, can only be successful in those cases which have existed under six hours, and where the occlusion is below the illiocecal junction. One of the best means of producing this is to introduce a tube into the rectum, and if air pressure cannot be readily obtained, inflate carefully with a syphon of vichy previously warmed. In every case the examination should invariably include a deep interrogation of the rectum. Frequently, this will avoid an abdominal operation.

It must not be forgotten that sterocacious vomiting occurs only when the obstruction is far down.

Had this paper been prepared for the Surgical Bureau, the writer would have gone into the technique of the various operations and their indications; but knowing all too well, from his bitter experience in his own practice, that a greater good can be derived by presenting the subject to the general practitioner, he has done so in the hope that discussion thus stimulated may help all present to an early diagnosis of this condition and thus lead to the saving of many lives now sacrificed.

There is but one great point that I would make regarding the operation itself, and that is that, fully as important, if not more essential, for the recovery of the patient after the removal of the obstruction, is the emptying and cleansing of the distended, inflamed bowel of its putrid septic contents; and this must be done, not only with dexterity, but with thoroughness. The stomach must be washed out thoroughly before operation, but also repeatedly afterwards, until the reverse peristalsis has ceased and normal bowel action has been re-established. In all these stomach washings it is my practice to add lemon juice—four drams to each quart of water. This not only prevents to a great degree further putrefaction, but also assists in the stimulation of normal peristalsis.

Greig Smith maintains that "no operation for intestinal obstruction is properly completed if the patient leaves the operating table with a greatly distended abdomen." Before the patient leaves the operating table it is a good procedure to dilate the anus and insert a rectal tube. Dilation not only facilitates subsequent passage of gas and feces, but by reflex action helps the patient to react from the anæsthetic.

Contrary to most surgeons, the writer prefers to simply hold the abdominal dressing in place by short adhesive straps in these cases, thus giving all possible freedom to abdominal respiration, which he believes stimulates earlier peristalsis. Before the operation a snug abdominal binder will do good, not only in relieving pain, but also by supporting the inflamed bowel until surgical measures can be instituted.

A few points in the after-treatment are as follows:

The Fowler position should be maintained until the bowel has taken on normal activity. The angle should be at least forty-five degrees. This not only stimulates by gravity, early bowel evacuation, but should septic peritonitis establish itself, assist in the gravitation of the septic material to the lower part of the abdominal cavity, where we know the peritoneum absorbs only at about the rate of one-tenth that of the upper abdomen.

If sepsis is profound, besides giving water freely, hypodermoclysis (salt-sugar solution night and morning, a liter may be given at a time), or a continuous colonic irrigation should be resorted to (20Gtt. to minute will be about 3 ounces per hour, which amount is readily absorbed).

The position of the patient should be frequently changed and deep respirations frequently stimulated, thus avoiding hypostatic conditions and bowel sluggishness.

These cases should sit up as early as possible. Kocher and Baker recommend the giving at once of ten grains of carbonate of bismuth, as the best substance to prevent further putrefaction.

Aluminum water is becoming a favorite after-treatment by the surgeons of the imperical school; we know why it is beneficial.

Even in those cases where the obstruction is readily removed without operation, the patient often dies of septive absorption of the putrid contents. So that the period of anxiety does not usually cease with the mere removal of the obstruction. Because this fact is not sufficiently appreciated by physicians, many a case unnecessarily dies, due to the discontinuance of further rational treatment after the first sign of gas or fœcal matter, following reduction.

Even should the case be only one of intestinal paralysis, and death be threatened from either distention or septic absorption, then equally with obstruction, the case demands operation with incision and cleansing of the bowel.

In closing, let me summarize with a few "don'ts."

Don't give morphine in acute abdominal pain, unless you know the cause, and above all, don't repeat the dose.

Don't try to relieve any obscure abdominal pain by the local application of anything that will injure the skin or superficial tissues; otherwise, the surgeon may be forced to operate through a septic area.

Don't fail to examine the rectum in all these cases; it may reveal a state of affairs that will avoid an abdominal operation.

Don't waste time trying insufflation in cases after six hours from time of beginning of marked symptoms.

Don't relax in your treatment as soon as you see a little gas or fœces from rectum; keep at things until sepsis begins to abate.

Don't delay operation if there is acute abdominal pain, collapse and muscular rigidity.

Don't waste a moment if you get stercoraceous vomiting.

Don't forget to wash out stomach often, as well as early and late.

Don't close abdomen until bowel above point of obstruction has been thoroughly emptied of putrid contents.

Don't hesitate for fear patient will die after operation, for with any good abdominal surgeon, "they die in spite of the operation, not because of it."

Above all, *don't* fail to "camp on the job" in all cases presenting symptoms of acute intestinal obstruction.

I thank you for your kind forbearance and the attention which you have given while listening to this paper on a class of conditions not frequently met with.

REPORT

OF THE

BUREAU OF OBSTETRICS.

" Artificial Dilatation of the Cervix—New Hydrodynamic Dilating Bag of Pomeroy," - - - - - - GEORGE HILLS ILER.
" Cystic Degeneration of the Charionic Villi—with Report of a Case and a Specimen," - - - - - - LOOMIS L. DANFORTH.

ARTIFICIAL DILATATION OF THE CERVIX—NEW HYDRODYNAMIC BAG DILATOR, "POMEROY."

GEORGE HILLS ILER, M. D.,
BROOKLYN, N. Y.

How often, even in what would otherwise be a normal labor, is the non-dilatable cervix the subject of much concern. In such formidable conditions as placenta previa, hemorrhage, eclampsia, prolapsed funis, what a source of anxiety to the accoucheur! The only remedy for this is, of course, the artificial dilation of the cervix in the shortest possible time with safety to the mother.

Such means of dilatation is divided into manual and instrumental, and instrumental again divided into solid metal dilators and inflatable rubber bags. The metal dilator has so far reached its limitations in the four-branched dilator of Bossi—example. This dilator is capable of doing the work, but is harsh and cruel, and may be exceedingly dangerous in unskilled hands.

The manual method, either by the single hand, beginning with one finger and working up, or bi-manually, are both very good, but slow and fatiguing. While nothing can be so intelligently employed as the hand of the operator, yet the length of time accompanied by the ofttimes great fatigue, as probably you have all experienced, will cause us to look for other means. In the inflatable rubber bags we have a method that at once recommends itself to the intelligent observation of any accoucheur, from the Barnes rubber bag to the one which I wish to bring before you. The Barnes bag was followed by that of Champetier, and that further modified by Voorhees; it is in four sizes. This bag, as you can see (example), exercises a safe means of dilatation by substituting the almost solid

tapering cone for the lack of the dilating bag of waters. The bag itself has no practical dilating power. The action is slow, and it will not fill the bill when time is to be considered. In the Pomeroy Hydrodynamic Bag—using the words of the author—"This form of bag provided a uniform dilating force, applied at the actual zone of resistance, and that it is at least equivalent in safety and efficacy as manual dilatation and lacks the fatigue to the operator.

The apparatus consists of three sizes of dilators, and may be described as a double compartment bag, each capable of inflation or collapse by means of its own tube, independent of the other. The upper portion serves its purpose as an anchor, and also measures the degree of dilatation by its expulsion for it cannot be withdrawn unless collapsed, or until the cervix is dilated to its diameter, at which time it will slip through of its own accord or with slight traction. The direct dilating force is applied to the lower portion (example). The author has reported eight cases, seven of eclampsia and one of complete central inplanted placenta with most excellent results. In one case there was a severe tear of the cervix and vaginal wall; this was not due to the bag, for the cervix had been already torn by two hours of manual dilatation before the bag was tried, and the bag used was a straight bag, not having the large, vaginal curve.

The method of use is as follows: The patient is prepared as for operation; the vulva and surrounding parts shaved and cleansed and the vagina douched, as for any other instrumental work; the patient anæsthetised to complete surgical anæsthesia, and placed on the back; thighs elevated and separated. Now, if the cervix is capable of penetration, even by one finger, the smallest size bag, which is straight (example), can be introduced; in my own experience I have used the Barnes bag for the preliminary dilatation. To insert the bag is perfectly simple. Having boiled the bags for five minutes, they are now ready. Roll the bag upon its long axis, seize with a pair of the application forceps, having a goodly portion of the bag beyond the blades; pass through the cervix, and when you feel satisfied that it has passed beyond the constriction, inflate the upper portion through its tube and clamp. Now remove the blades of the forcep. The inflation is best secured by means of a division syringe. The resistance against the syringe will tell you the degree of distensibility. After filling the upper compartment, make gentle traction upon the tube to see if it is firmly anchored within the uterine cavity. If so, proceed to fill the lower compartment. Here again the resistance offered to the syringe will tell you the power you are exerting. At any time you can release the clamp, allowing the bag to collapse, and see the progress of the dilatation. At all times the amount of dilatation and amount of pressure are under perfect control.

During the last stage of the dilatation it is advisable to allow the patient to partially recover from the anæsthetic, for the impulses, stimulated by the distention of the vaginal canal, will cause the

patient to make voluntary expulsive effort, which will materially aid in obliterating the lower uterine section, and also aid in the expulsion of the portion of the bag in utero.

When the large bag has been expelled, you will find, not only that the cervix, but the whole vaginal canal has been fully dilated so that version can be performed or forceps applied, and a fœtus at full term successfully delivered.

In placing the large bag, it is essential that the concavity be kept looking toward the symphisis.

Dr. Pomeroy claims that full dilatation of the vaginal and cervical canal can be accomplished from twenty minutes to three-quarters of an hour.

In primipora, at under term, with a long cervix, you are very prone to have contraction, or better, retraction, take place after the removal of the bag, when, of course, you will have to replace and dilate again.

The advantages claimed for the bag are, first, the perfect control, secondly, the lack of fatigue to the operator, thirdly, the rapidity of dilatation without harm to the patient, fourthly, the application of the dilating force to the actual site of constriction, and that being exerted equally in all directions; fifth, the anchorage preventing slipping, and lastly, in the large sized bags, the dilatation of the vaginal canal which power is possessed by no other dilator.

DISCUSSION.

PRESIDENT SCHENCK: I feel that we are very fortunate in having with us to-day the inventor of this bag, and I assure you it gives me great pleasure, which I am sure every one of you will participate in, to extend the courtesies of the floor, in opening this discussion, to Dr. Ralph Pomeroy, of this city.

DR. RALPH POMEROY: Mr. President, Ladies and Gentlemen—I felt very strongly that I wanted to be here to hear the actual experience that Dr. Iler had with that bag, but I was unfortunate in not being able to get here in time. I do not feel quite so much impressed with the lack of possibility of damage with that apparatus as Dr. Iler would like to impress you. I want to warn you that the apparatus is actually as powerful as any metal dilator, and must be used with discretion. The small size I have not seen do any damage. I once or twice had a moderate laceration of the vaginal portion of the cervix with the large dilator. At first sight it would appear as if the large apparatus were too large. Its dimensions, however, are correct as to the possible dilatation of the genital tract without doing damage. The important thing is not to be in a hurry. Two particular points, that I doubt if the Doctor made special explanation of, are, that the upper compartment in the bag should be allowed to be somewhat soft. In filling it, of course this

upper part is concealed. When the upper compartment is full on the inside, the tenseness of the compartment can be palpated from below, and as soon as it is actually full and tight, which is detected by a sense of compression at the injector, about an ounce, or sometimes more than that, can be allowed to escape, so that the upper compartment is to some extent compressible as we let out part of the contents. That lessens the liability of doing damage as it goes through, of course.

Another thing is that, particularly in a primipara, where the vagina is to be extended as well, fluid can be let out. Of course, the bag is *in situ* in this manner (indicating); more or less can be allowed to escape from the lower compartment and the cervix examined, and then it can be very quickly filled again.

The mechanical principle of this dilator has been pretty well censured. I am not ready to stand for the proposition that the dimensions and shape of the apparatus as now presented are final. I have been constructing an intermediate size. The first temptation in making use of this apparatus seems to be to get the impression that it is intended to induce labor. It is a peculiar fact that the mere dilatation of the cervix will not induce labor. It is necessary to have the presence of a foreign body in the lower uterus for some time in order to induce actual labor pains in the patient. This large apparatus is intended to take the place of manual dilatation that would be used with the patient under an anæsthetic. It is too bulky to remain *in situ* with the patient conscious. If she is conscious she makes violent efforts to expel this artificial fœtus which is in the vagina, with the after-coming head, so to speak; but with the smaller size, intermediate between these two, I find that the patient will tolerate the apparatus in place, conscious, and that from time to time small amounts of fluid may be pumped into this lower compartment, which has a very distinct effect in bringing on labor pains.

It is also a question that I am somewhat in doubt about, in forming an apparatus for the induction of labor pains, whether the upper compartment will not have to be elongated in order to make more pressure on the retraction ring, which has a very decided tendency to shut down again after the upper compartment has dropped into the cervix proper.

I merely refer to these things to impress upon you that for myself I do not quite feel that this apparatus has reached its climax. The thing I wish to make the claim on is the principle of dilatation, which is entirely different from anything else that has been put on the market, or that I can find any previous invention of. I have not so far had anyone report to me that it was a terrible and dangerous instrument, but I hope that those who do experiment with it will inform me if they are unfortunate enough to have any disastrous results in working with the apparatus. I thank you very much, Mr. President, for your courtesy.

LOUIS FAUST: To one who has been accustomed to manual dilatation, and in rare cases to the use of the Champetier bags, the pre-

sentation of this bag of Dr. Pomeroy's is rather interesting. It opens up an entirely new method of dilatation. I have used the Champetier bag a number of times with very good results, but more particularly in those cases where there is an early rupture of the membrane and very little or no labor, in which, if it were allowed to go on, the head would have to dilate the uterus. I have used the Champetier bag with very nice results in those cases. I never have had the courage, if you will call it that, to use the bag in eclampsia. I feel in those cases that time is very valuable, and unless Dr. Pomeroy's bag solves the problem, I do not think any bag in existence to-day will give you dilatation soon enough to safeguard the life of the patient, particularly the life of the mother. I have used generally manual dilatation, dependen upon that, and in the last two or three years I have used Bossi's dilator, which someone said was rather antiquated, but I beg to differ from that view. I think the Bossi dilator, carefully used, keeping in mind the resistance of the os, and not being in too great a hurry—and yet it can be done in a reasonably short time—is still most serviceable and has not outlived its usefulness. In placenta prævia, I think the sooner we can get through the placenta and into the amniotic sac, the safer the patient is; and in eclampsia as well, time is valuable, particularly if the patient is very toxic.

I had a case lately in which, unfortunately, the patient died; I had a post-mortem demonstration of the Bossi dilator in its effect to the cervix. The case was one to which I was called in the absence of a physician who was out of town, and it proved afterward, on post-mortem examination, to be one of acute yellow atrophy of the liver. The toxæmia came from that source. The os was opened with a Bossi, and in the post-mortem examination the amount of damage was found to be very slight; and true, I took thirty to forty minutes to dilate the cervix, but I did it with a great deal of trepidation, fearing there might be more damage, from having read so much of the damage done. But I feel, after all, that Dr. Pomeroy has given us food for thought, and the question occurred to me while the Doctor was reading the paper, whether possibly the danger of a prolapsed funis or malposition would not be increased by the use of the Pomeroy bag. That, of course, remains to be seen in the future.

WALTER G. CRUMP: I want to add my testimony to the efficacy of the Pomeroy bag. I have had a pair of the bags for about six months. I secured them after hearing Dr. Pomeroy read a paper and give a demonstration. I have used these bags in four cases, and I find them a great advantage over anything that I have ever seen in the way of a dilator for the cervix, especially in pregnancy. You can simulate the intermittent character of labor pains in dilating the lower cavity of the bag, and in doing so, by using your sterile water and simulating the intermittent character of the pain, you allow the re-establishing of the circulation at the lower uterine segment, with consequent infiltration, and you can thin out the

cervix that way just as well as you can with any hand dilator I have yet seen. I have used the small bag in a case of miscarriage, a case that had been about four months pregnant, and had been flowing for some weeks previous to having been sent to me. I took the case to the hospital and found the uterus extended up to about the level of the navel. The woman had no symptoms of sepsis, although she had been flowing constantly, and the uterus was only dilated to admit the tips of two fingers. I wanted to dilate rapidly and deliver, and did not want to injure the cervix any more than I had to. So I used this small Pomeroy bag in that case, and delivered the woman of a dead fœtus which was mummified, which was about three inches long, and I delivered her also—it was a twin pregnancy —of another fœtus which was not mummified, and which probably died either at the time of the delivery or just before. The woman had had, undoubtedly, a double sac, and the first child had died probably three or four weeks before the second child.

In another case in which I used this apparatus I used the large bag only, and that was a case of foot presentation, where the child was suffering symptoms of asphyxia, the mecominin was being passed down through the cervical canal, and haste was an essential factor, if a live baby was to be delivered. I used the Pomeroy bag and simulated the intermittent character of uterine contractions, rapidly dilated the cervix, and I do not think it took me more than from five to seven minutes before that cervix got to full size. At the same time I was dilating the lower part of the parturient canal, dilating the vagina, and delivered that baby, though it was as blue as a whetstone, and succeeded in resuscitating it; and I think the saving of the life of that baby was due to the fact that I had a pair of Pomeroy bags. Therefore, I want to add my testimony to the efficacy of the bag. I think Dr. Pomeroy has made a great addition to obstetrical art in the invention of this bag.

F. W. HAMLIN: I am very sorry to confess that I have never used the Pomeroy bag up to the present time. I think, however, we shall certainly have to make a trial of it, as it seems to be so highly recommended by the various observers. Heretofore we have been fairly well satisfied with the Voorhees bags in the dilatation of the cervix, and I am not yet prepared to state that we are dissatisfied with the use of those bags. We have certainly had very good results with them, and have no reason to complain of their efficacy. Yet, I can see that this Pomeroy bag which I have read about in the literature, but have not used, possesses elements of great advantage, possibly, over any bag which we have as yet at our disposal, and I am certainly very much inclined to make a test of the Pomeroy bag in some of the obstetrical clinics with which I am connected.

As regards the use of the Bossi dilator which Dr. Faust referred to, I must say that I have also had no experience with that, but I am not favorably impressed with the instrument as I have seen it. It strikes me as a very powerful instrument, which it undoubtedly is,

and which is capable of doing a great deal of harm, and is not under the control of the tactical sense of the finger, such as you have in dilating manually. I remember a discussion which I heard about a year ago in the New York Academy of Medicine in which one of the best known obstetricians in New York city made the statement that under no consideration would he countenance the use of a Bossi dilator or use it again in his practice; that he had seen most dire and lamentable results from its use, in very extensive lacerations of the cervix, extending up to and beyond the vaginal junction, and even into the peritoneal cavity; and for his part, he would have no more of it. Now, I give you that testimony for what it is worth, coming from one of the most prominent obstetricians in New York city. Personally, as I have said, I have had no experience in its use, but I should be a little afraid of its use and should prefer to dilate with my fingers, even in a case where haste was necessary. I believe I have yet to see a case where you could not dilate the cervix either by means of the Voorhees bags or by means of digital dilatation, in plenty of time to save your patient, if she is going to be saved.

CYSTIC DEGENERATION OF THE VILLI OF THE CHORION.—WITH REPORT OF A CASE—AND A SPECIMEN.

L. L. DANFORTH, M. D.,
NEW YORK CITY.

The specimen which I present to you to-day is an extremely interesting one, and is an example of a rare form of disease of the villi of the chorion. This peculiar degeneration of the chorion has attracted much attention from the time of Ætius Von Ameda in the sixth century to the present day. Various synonyms have been employed to designate the affection, such as hydatidiform, hydatiod, cystic, placental or vesicular mole; myxomatous degeneration of the chorion; dropsy of the villi of the chorion; cystic disease of the ovum; uterine hydatid or molar pregnancy.

First definitely described by Schenk Von Grafenberg (1564) the most extraordinary theories have been advanced to account for its occurrence. From Hearst's Text Book on Obstetrics (P. 108) we learn that Regnier de Graff (1678) thought that each vesicle or cyst was an unfecundated ovule. The belief had once prevailed that each vesicle was a living embryo. Priestly quotes from Ambrose Paré that "the Countess Margaret Hagenau brought forth at one birth 365 infants, whereof 182 were said to be males, as many females, and the odd one a hemaphrodite." (1262 A. D.) Pepys

records in his diary that he visited the house in which this remarkable delivery occurred, and saw the brass platters on which the children were carried before the bishop of the diocese for *baptism.* The opinion of Ruysch (1691) and Albinus (1754) that the existence of the innumerable little cysts in the uterus and their final expulsion were dependent upon some disease or alteration of the ovule, was at last generally adopted.

In the early part of the nineteenth century it was claimed by Percy (1811) Cloquet and Mme. Boivin (1827) that the vesicular disease was due to echinococci. Velpeau was the first to indicate that the cysts were nothing but distended choroin villi, and since Velpeau's announcement, cystic degeneration of the villi has been attributed to hypertrophy and œdema; to disease of the blood vessels; and to disease of the lymphatics.

Virchow, in 1883, stated that the process was essentially a myxomatous degeneration of the connective tissue of the choroinic villi, and designated it a myxoma-chorii. This view was held universally until Marchand, in 1895, demonstrated that the essential feature of the affection was to be found, not so much in the connective tissue as in epithelial covering of the villi. He showed that the syncytium and Langhan's layer of cells underwent profuse and irregular proliferation penetrating the fibrin layer, and making their way into the depths of the decidua, and not infrequently into the musculature as well. At the same time the blood vessels of the terminal villi disappeared and the stroma degenerated, so that in advanced cases its nuclei failed to take up the usual histological stains, and the cells presented a necrotic appearance. Moreover, inasmuch as the fluid contents of the vesicles failed to give the characteristic reaction for mucin, Marchand felt justified in attributing them to œdema. (Williams, P. 573, 1907.)

The possible relationship which exists between this disease and chorio-epitheloma is an interesting one. It is now recognized that growths of the chorio-epitheliomatous type from a quite characteristic group climically, pathologically and developmentally, and that they should be classed neither as sarcomata nor as carcinomata, but as a distinct group *sui generis.* That these growths arise in connection with pregnancy, and result from a malignant proliferation of the epithelial elements of the choroin is now well established, and furthermore it is now recognized by numerous well authenticated observations that nearly one-half the cases of chorio-epithelioma are preceded by cystic disease of the choroin. Galabin stated ten years ago, before the Obstetrical Society of London, that out of ninety-six cases then recorded, forty-nine had been preceded by vericular mole. The statistics of recent years, judging from personal recollection of the literature, will substantiate the relationship between these two conditions. But whether such relationship exists in all cases, it is difficult to say.

"Newman, in 1897 held that it was possible to differentiate between two forms of hydatidiform mole—malignant and benign—

one of which was, and the other was not, followed by the development of choroi-epithelioma. He considered that in the former the proliferating epithelium invaded the stroma, while in the latter it was limited to the periphery of the villus." (Williams.) It is now accepted by most authorities that there are two varieties of cystic mole, but these are difficult to separate, inasmuch as the differences in the early stages are biological rather than histological. Another frequent, if not invariable association of the disease, is with multiple corpus luteun cysts of the ovary. So frequently has this association been observed that a causative relation between the ovarian disease and the degeneration of the chorion (vesicular mole) is now believed to exist. In view of the peculiar nature of this disease and its undoubtable relation clinically to the other serious diseases mentioned, we are no longer justified in considering cystic degeneration of the chorionic villi as an affection which is cured when the uterus is emptied. The possibility of further trouble which would be made known by continued menorrhagia, or the formation of a tumor of the ovary, should be kept in mind, and the patient advised to report promptly on the appearance of unusual symptoms.

Pathological Anatomy—The appearance of a vesicular mole is peculiar, as you will see when you examine the specimen presented. It consists of a mass as large as a good-sized cantaloupe; it may be as large as a man's head. In this specimen a portion, the soft part, is covered with decidua, broken in places, through which may be seen in spots, innumerable small cysts; some as large as grapes, and others no larger than a good-sized pin head, connected with each other or to the base of the chorion by pedicles of varying sizes and thickness. The walls of the cysts are thick and white, like grape stems, though less green and shiny, and more translucent. The fluid these little cysts contain is usually clear, though sometimes slightly pinkish; there is also mucin and albumen in considerable quantities. Within the center of the mass may be seen in this specimen the remains of a sac still adherent to the mass; this is the amnion in which the embryo was contained, though no trace of it was found. The cysts which abound in such great numbers are formed from the terminal extremities of the chorionic villi. As a result of the changes in the epithelial covering of the villi, and ultimately in the stroma and the blood vessels, the villi are converted into transparent vesicles with clear viscid contents. This specimen does not show all the cysts that were expelled, a considerable quantity being lost in the discharges. It has been the writer's fortune to deal with three cases of this interesting condition. In both the others the quantity of cysts expelled was much larger than in this case.

Etiology—The cause of the disease is obscure. There are many theories, but none which seems to be worthy of credence. Virchow thought that the endometrium was at fault, while Marchand and most recent writers hold such changes are secondary. Williams states that it is not unlikely that the process originates primarily in

the ovum, plausibility being lent to such a view by the fact that in rare cases of twin pregnancy one ovum may be perfectly normal, while the other presents the lesion in question. It is hardly probable if the endometrium was the primary cause, that the changes would be limited to the ovum.

Clinical History—The patient from whom this specimen was removed was Mrs. P— at thirty, and married one year. Health previously good, no menstrual irregularity until she became pregnant in November, 1906. Missed three periods, when she was seized with hemorrhage, with no pain. Hemorrhages occurred at irregular intervals, sometimes quite profuse, and then for several days would be followed by a slight brownish discharge. Was called to see the patient on March 15, 1907, in consultation, and the case was placed in my care by the physician in charge. The usual signs of pregnancy were present—cervix soft, patulous, blue color about cervix and vagina, and the usual breast signs. The uterus was enlarged, but not more so than it should be for the time in pregnancy at which she was supposed to be. Whether the uterus had grown larger than it should have been in the early months was not made plain. The organ seemed more "boggy," fibroid-like, than is characteristic in pregnancy. The patient was kept in bed, but the flowing returned from time to time. Patient was kept in bed for a week or more, then allowed to sit up, and flowing was not increased thereby. There was no pain to speak of with any of the hemorrhages. The latter on one or two occasions were rather excessive, and patient became somewhat anæmic. On April 10th there was a profuse hemorrhage, which came suddenly, with some pain, as of an impending miscarriage, but the hemorrhage had practically ceased by the time the writer was able to get to her bedside. The cause of the hemorrhages was not known up to this time. It was too early in pregnancy for such severe hemorrhages to occur from placenta prævia. By this time the uterus was smaller and firmer than at the first examination in March, and the os had closed and the cervix was firmer. In other words, the usual signs of pregnancy were less marked than the month previous. Having ruled out placenta prævia, cystic degeneration of the chorion was thought of, and the patient directed to watch for the ruptured cysts in the discharges, but none was found. Feeling certain that if pregnancy has existed, as there had been every reason to suppose, it was not progressing favorably, and that the embryo had ceased to develop, it was decided to empty the uterus. Patient was sent to a private hospital, and after suitable preparation a Vorhees bag was introduced within the cavity of the uterus; six hours later the largest sized bag was easily introduced, and within ten hours contraction came on, and rapidly the mass which is presented was thrown off with considerable hemorrhage. The uterus was curetted with a large, dull curette, irrigated and packed lightly with gauze. The convalescence was uninterrupted.

We may properly ask by what symptoms may degeneration of the

villi of the chorion be suspected or discovered. If the alteration be slight, some of the usual signs will be wanting, and then a diagnosis will be almost impossible. If, on the contrary, the change is so great as to completely alter the ovum, the affection may be suspected or occasionally discovered. All observers admit that *attacks of hemorrhage* are common in such cases, and they almost always coincide with an unusual development of the uterus, whose size is no longer in conformity with the presumed period of pregnancy. At the second or third month it may be as large as at the fourth or fifth, or even larger. In the first case seen by the writer the patient had discharges of pinkish water; her general health suffered; she was weak and anæmic and had a little fever daily. The diagnosis was made in this case by the presence of the ruptured cysts. The mass thrown off was the largest I have ever seen. In the second case, profuse hemorrhages in the early months were followed by spontaneous expulsion of the mole.

To summarize the symptoms for diagnosis, we may say that hemorrhage in the early months without pain and an overgrowth of the uterus in excess of the period of pregnancy at which the woman is supposed to be, and the peculiar boggy feel to the uterus are characteristic signs. The discharge may be watery, albuminous, pale or pinkish in color, and if of this character is apt to contain the small emptied cysts, as the fluid from the rupture of the cysts and the latter come away with the fluid. The uterus may, after the fourth month, if ovule is carried, shrink and become hard, and the usual signs of pregnancy may disappear. While nature may cast off the mass spontaneously, generally before the sixth month, it may be retained until the eighth or ninth month. In thirty-two cases collected by the celebrated Mme. Boivin, in each of three it lasted until nine months; three others to ten months, while one was not delivered until eleven months and another at fourteen months. There are instances on record where a "cystic" mass has been expelled, and the pregnancy continued to term, when a healthy child was born. Such cases were probably instances of twin pregnancy in which the cystic degeneration affected one ovum, the one that was discharged, while the other lived.

Treatment.—There can be only one course to pursue as soon as the diagnosis is made, and that is to empty the uterus; and even if the diagnosis is not certain, if the woman is having hemorrhages, and her health is endangered thereby, and it is certain, as can be readily established in most cases, that the embryo is not developing properly, the indication is to empty the uterus.

There is no reason to delay, and every reason to act when the conditions are as stated. If the cervix is soft and patulous, a small-sized bag may be introduced, or the way prepared by packing the lower uterine segment and cervix with gauze. This softens the cervix and will often bring on contraction. If it does not, the rubber bags may be used. Contraction will follow in a few hours and the uterus will empty itself.

Irrigation afterwards is advisable, and possibly intra-uterine packing. The patient should be advised to report once in six months, in view of what has been stated in reference to the possibility of the development of chorio-epithelioma; and the tendency to the development of tumors from the interior cells of the ovary is worth remembering in this connection.

DISCUSSION.

F. W. HAMLIN: There is not very much that I can add to the very accurate and complete description of this disease given by Professor Danforth. It has been my fortune to meet with two cases of this disease or complication in my obstetrical work, one of them being in hospital practice and the other in private practice. The case in hospital practice was admitted to the hospital with a diagnosis of probable miscarriage. She was supposed to be at about the fourth month of pregnancy, and was referred to me for treatment. Upon examination externally, I found the fundus extending as high as the umbilicus, which of course would indicate a pregnancy at about the sixth month, this corresponding to the fact, as stated in the paper, that the uterus is, as a rule, larger than would be supposed at that time. Upon examination vaginally, I found a soft, dilatable cervix, and was enabled without very much difficulty to dilate the cervix sufficiently so that I could get my fingers into the interior of the uterus and examine the mass which it contained. I found this condition of bogginess, which the Doctor has mentioned as characteristic of those cases, a distinctly boggy feeling to the uterus externally. I found this soft mass. I did not know what it was. A diagnosis had not been made. Dilating the uterus still further, I was enabled to scoop out this material by handfulls until it had half filled a large size water pail. Examination showed at once the nature of the disorder, that it was a case of cystic degeneration. Curettage was then performed, and the uterus was not packed for some time in that case, but I ordered that at intervals of two days the interior of the uterus should be touched with Churchill's compound tincture of iodine, thinking that might possibly prevent the development of the growth in the subsequent pregnancy. That case has been lost to sight; I have not heard anything from it since she left the hospital, so that the subsequent history I cannot give you.

The second case was one which occurred in my own practice—a private case—a woman who came down here to the city from an up-country town. On that visit she had a severe hemorrhage from the uterus. It seemed she had had several of these hemorrhages in the course of a few months. She was supposed to be pregnant. She had been seen and treated by most of the physicians in the town in which she lived, and various diagnoses had been given as to the causes of her trouble. Fortunately for me, with this hemorrhage

she had expelled a large mass from the uterus, which had been preserved, and a very casual examination was sufficient to diagnose the trouble. It was again a case of this nature. I immediately sent her to the hospital, where curettage was done and the same treatment applied—the compound tincture of iodine, and she has been under observation two or three years. She has had one miscarriage since, but there has been no development of the disease again, and she has had on recurrence of the hemorrhage.

WALTER GRAY CRUMP: The talented author of this paper has left very little to say in discussion, having covered the ground so thoroughly. I will present, however, this specimen of hydatid degeneration of the chorionic villi. I will first read you a few notes that I have culled this morning from my back history of this case.

Mrs. W., age 33, mother of one child; had several miscarriages; skipped three periods. Supposed herself normally pregnant when, without any known cause, pains established and flow began. Went to J. Hood Wright Memorial Hospital; was given anæsthetic and curetted by one of the house doctors. A few days later, as flow continued excessive and had high temperature following chill, was again anæsthetized and curetted, supposedly by one of the attending surgeons. Remained in hospital six weeks, during which time flow persisted. Finally discharged from hospital and told that flow would soon stop. Two weeks later, as flow still continued and patient had become very weak, I was called in. At the J. Hood Wright Hospital nothing was said about the case being other than an ordinary miscarriage. Upon examination, I found uterus about the size of four months' pregnancy. Brought out some clots that were lying in the vagina, and washed them under the faucet. We found several little cysts in the clots which I had taken out. Sent the case immediately to the Hahnemann Hospital, and the next morning, early, curetted her. I knew what I had to deal with, and was prepared for a pretty active hemorrhage, and was not disappointed. Removed over a quart of these cysts; have exhibited this specimen at various societies and people have taken a few of them, and these are all that are left to prove the case (Laughter). The hemorrhage was very profuse in this case; packed the uterus with gelatinized gauze, removing it piecemeal, about a foot at a time, until the uterus had contracted down upon itself, and the hemorrhage ceased. Followed this case for some time, and six months after her delivery, knowing the possibility of *decidnoma malignum* in these cases, and as she had developed then a good deal of abdominal pain and had a mass in her right side, I did a laparatomy on her and found a cystic ovary with adherent tube and hydrosalpinx. I removed the tube and ovary, sent same to a pathologist, who reported nothing malignant. Kept watch of the case for nearly a year after that. She had no further symptoms. I have not seen her for more than a year now.

REPORT

OF THE

BUREAU OF OPHTHALMOLOGY AND OTOLOGY.

" Eye Symptoms Suggestive of Complications in the Accessory Nasal Sinuses," - - - - - - - J. IVIMEY DOWLING.
" The Clinical Significance of Ciliary Neuralgia," - - FREDERIC G. RITCHIE.

RELATION OF NASAL AFFECTIONS TO OCULAR DISEASES.

J. IVIMEY DOWLING, M. D.,
ALBANY, N. Y.

The accumulated experience of recent years shows that inflammatory diseases of the eye are largely dependent upon some preexisting or complicating inflammation of the nares or its accessory sinuses. Therefore, the successful treatment of a large proportion of ocular inflammations is influenced by the condition of the proximate nasal parts, and for the speedy resolution and satisfactory cure of an ocular inflammation, consideration of the nasal possibilities is essential.

These statements are facts open to proof, and demonstrable in both acute and chronic affections. However, the rhinal complications may be absent, or so mild that they are easily overlooked; but in recurrent or chronic inflammation of the eyes, some abnormal state of the tissues or membranes of the nose or accessory sinuses is almost always present, and my personal experience leads me to the belief that chronicity or recurrence of an ocular inflammation is almost positive evidence of some existing inflammation of the nasal parts.

The diseases in which I have positively observed such relationship have affected the cornea, iris, lens, vitreous and retina. As for the optic nerve, choroid and sclera, they are ofttimes associated with rhinal complications, but I have been unable to determine the degree to which the nose is responsible, perhaps because such affections are deeper seated and less likely to yield to any treatment, or because of faulty observation and deductions.

Various theories may be advanced in explanation of these phenomena, but I will merely suggest as the most likely reasons that of proximity of tissues, vascular distribution and nerve relationship, bearing in mind most particularly the distribution of the *nasal nerve and its communication with the long ciliary nerves.

Diseases of the cornea, such as phlyctenular conjunctivitis and corneal abscess, I have frequently found associated with suppurative affections of the sinuses, and with relief of such conditions the corneal diseases have rapidly resolved. It is my belief that the origin of idiopathic corneal abscess may be thus explained, and the source of infection traced to pus retained in some of the sinuses which in my experience has most often been traced to the ethmoid cells and maxillary sinuses. Various forms of iritis are associated with suppurative ethmoiditis, affecting more frequently the anterior cells. Relief of such conditions has been followed by rapid resolution of the iritis.

In two cases of infantile cataract I have observed hypertrophic conditions of the nares with adenoids present and purulent nasal discharge. These cases prove nothing, but are strongly suggestive that purulent secretions absorbed from the nares may so influence the nutrition of the lens as to permit it becoming clouded or cataractous. One case will be cited in which the lenses were diffusely clouded with marked result on vision, and at other times were sufficiently clear to permit moderate degree of vision. These changes were directly proportionate to the degree to which the nose and pharynx were affected at various times. Vitreous opacities are frequently associated with purulent conditions of the nose or acute turgescence affecting more decidedly the middle turbinated bodies.

Serous retinitis seems to be directly the result of altered states of the nares in which the vascular tone is lowered.

Erratic refractive states may be the result of such conditions, and

---

* "The *Nasal Nerve* is a branch of the ophthalmic division of the fifth nerve. It gains access to the orbit through the sphenoid fissure, and passes between the two heads of the external rectus muscle and between the divisions of the oculomotor nerve. It then crosses to the inner wall of the orbit, passing over the optic nerve and immediately under the superior rectus muscle, taking a position between the superior oblique muscle and the internal rectus muscle. After giving off the infra-trochlear branch, it leaves the orbit through the anterior ethmoid foramen. It then takes the following course: Having passed through the anterior ethmoid foramen, it again becomes an occupant of the cranial cavity, lying between the dura mater and the cribiform plate of the ethmoid bone. Here it leaves the cranial cavity through the ethmoid fissure, or nasal slit at the side of the crista galli, and becomes an occupant of the nasal fossa. It has thus traversed in succession the cranial cavity, the orbit, the cranial cavity again, and, finally, the nasal cavity. It then gives off an internal and an external branch, and continues as the anterior or terminal branch.

"The *internal* or *septal branch* supplies the anterior part of the septum.

"The *external branch* supplies the anterior portion of the middle and inferior turbinated bones and the mucus membrane of the outer nasal wall.

"The anterior or terminal branch runs downward in the groove on the under surface of the nasal bone, passes between the lower edge of the nasal bone and the superior lateral nasal cartilage, and supplies the sides and tip of the nose.

probably the most easily proven for vision may be improved and the refractive states absolutely altered temporarily after a brief nasal treatment for the relief of turgescence of the erectile tissues.

I have referred to infantile cataract, and herewith append a brief history of two cases.

The first is that of a colored boy, age three. At time of first consultation he presented the typical picture of tuberculous lymphatics. The nose was blocked by enlarged turbinates of the soft, spongy variety, and adenoids were present, but of moderate size. The usual catarrhal symptoms were present. He was blind with soft cataracts. The treatment consisted of administration of calcarea carb. 3x continuously for three years. Needling operations established useful vision, so that the boy is now obtaining a rudimentary education.

The second case was a child who presented the following symptoms at time of first consultation, October 10, 1905: Name, C. R. R., age 18 months. The patient had the "cold habit," taking cold on least provocation. He was a mouth-breather, due to the state of the nose and presence of adenoids. The ears were involved to the degree that chronic otitis media catarrhalis was a warranted diagnosis. Chronic catarrhal conjunctivitis was present, and at this time the lenses were *slightly clouded* and vision possible, but difficult, as determined by use of candles and other bright objects. In addition, the fontanelles were still open, and only two teeth had appeared. Tubercular glands were present. Furthermore, the parents stated that at times the vision was considerably worse than at that immediate time, and at such times the pupils seemed to be covered with a film. Subsequent observation proved this, for I found that after a brief course of treatment there was improvement of the cloudiness of lenses coincident with improvement in the condition of the naso-pharynx, permitting more satisfactory breathing. Then, again, after an attack of pneumonia, with increase of the naso-pharyngeal

---

"The *branches of the nasal nerve* in the orbit are four in number; the long root to the lenticular ganglion, the two long ciliary nerves, and the infra-trochlear nerve.

"The *branch to the lenticular ganglion*, known as the long, upper, or sensory root of that ganglion, arises from the nasal nerve as it passes between the two heads of the external rectus muscle. It is very slender, and measures about one-half of an inch in length. It passes along the outer side of the optic nerve, and enters the posterior superior angle of the lenticular ganglion.

"The *long ciliary nerves* are usually two in number. They arise from the nasal nerve as it crosses the optic nerve, and run along the inner side of the optic nerve to enter the eyeball by piercing the sclera. One of these nerves usually unites with one of the short ciliary nerves. Their course between the sclera and choroid is described with the eyeball.

"The *infra trochlear nerve* arises from the nasal nerve just before the nerve enters the anterior ethmoid foramen. It traverses the inner orbital wall below the superior oblique muscle and its pulley. It forms a loop of communication with the supra-trochlear nerve at times behind, but usually in front of, the pulley of the superior oblique muscle. It supplies the region around the inner canthus of the eyelids, including the lacrymal sac and the lacrymal caruncle." (*Deaver.*)

conditions and enlargement of adenoids, the eyes were completely blind and the lenses diffusely clouded. With recovery and improvement in the local naso-pharyngeal conditions, the eyes improved until the lenses were merely hazy and the visual sense readily determined by the same tests as previously employed. Finally, operation for removal of adenoids was performed April 16, 1906, Dr. William P. Faust, of Schenectady, being present. Subsequently, the eye symptoms were aggravated, and the child died about one week after the operation. No autopsy was obtained, so fuller data was not possible. However, examination of the urine at different times revealed no organic lesion of kidneys. The above case is of value because, irrespective of the systemic conditions, the eye symptoms were always better or worse, according to the state of the complicating conditions of the naso-pharynx. The remedy that seemed to relieve most was calcarea carb. 3x.

Another case of interest under this head is that of Mrs. LeRoy M., aged 49, who for six years had been under treatment for phlyctenular conjunctivitis. Local treatment and change of glasses by various physicians failed to secure relief. I examined this patient for the first, November 24, 1906. Both eyes were affected, and the cornea of each nearly encircled with phlyctenules. Examination of the nose and accessory sinuses showed pyæmic state of the ethmoid cells and maxillary antra positively, and probably in the other sinuses. Exophthalmic goitre was also present. Under the use of local nasal treatment and collyria she improved, but had recurrences until finally, operation on the maxillary antra was performed, which was followed by subsidence of all ulcerations within forty-eight hours, and likewise relief of pain within the eyeballs. This improvement has continued since March 22, 1907, when the operation was performed. In addition to the above improvement, the vitreous chambers which had been clouded became transparent, and vision was subjectively improved although, unfortunately, the records fail to show the positive degree of improvement as determined by Schnellen tests.

The remedies employed were lycopus mercurius, dulcis lx and sulphur lx, and also galvanism over the cervical sympathetic, applying the positive pole over those regions and the negative at the wrists.

The above cases are submitted for consideration merely because *diseases of the eyes were greatly benefited only after successful treatment directed to the relief of the complicating nasal conditions.* In themselves they prove nothing, but bear evidence which, if repeatedly sustained, will warrant positive statements as to the causal relationship of nasal diseases to those of the eyes.

In the first case of cataract no attempt was made to establish a relationship, but in the second there was a definite aim; and results warrant the belief that the nasal affections were an important factor in the cause of the cataracts, for they were definitely better or worse, according to the state of the naso-pharynx.

Now, as to the appropriate treatment of these complications. In children, I find the following to be a most serviceable solution for nasal irrigation.

℞	Adrenalin Chloride (1-1000 P. D. & Co.)	gtt. xxx.
	Enzymol	dram 1
	Aq. Distil. q. s. ad	oz. 1
M.	Sig. Irrigate the nostrils by means of a medicine dropper, as directed.	

This prescription serves to dissolve mucus accumulations, and open the nasal cavities so as to permit of free drainage.

In adults I employ nasal tampons applied between the middle turbinated bodies and septum, and sufficiently long to reach from the anterior extremity of those bodies to the pharynx posteriorly. After a trial of many solutions I now employ argyrol, forty grains to the ounce. When properly placed, these tampons act by the force of capillary attraction and drain the proximate cells and sinuses of retained pus. They frequently excite a free mucus flow and repeated sneezing, which further aids in the cleansing. In addition, they serve to determine whether the anterior, middle or posterior cells are chiefly diseased, for according to the location of the purulent accumulation the tampon is stained yellow, or in case of extensive infection, the tampons come away entirely changed in color.

This simple measure, if properly used, is a valuable diagnostic aid and effective remedial agent. Subsequent to the use of these tampons the nasal cavities should be irrigated by means of an alkaline solution.

DISCUSSION.

G. DEWAYNE HALLETT: This interesting paper of Dr. Dowling's deserves more thorough discussion than I have prepared for it, and, not covered by my printed discussion here, I observe that among the patients he mentioned he said he had observed a positive relation between affections of the corneas aries and the retina. Aside from those he gave details of, I think he gave no details of the affections of the corneas aries or the retina.

In my clinic I have repeatedly observed cases of children, five to ten years of age, with blinking, photophobia, and lacrymation, and very little refractive error, who made an entire recovery from these symptoms on removal of adenoids following an examination in the Throat Department, to which I had referred them. Transitory lenticular opacity has been observed in diabetes (Alt), in periods of high specific gravity. Most writers, in speaking of ocular disorders in diseases of adjacent sinuses, confine their descriptions to affections of the frontal, ethmoidal, sphenoidal, and maxillary sinuses which cause cellulitis, exophthalmos, and tumors with their various results, while a few mention that the chronic inflammatory eye dis-

eases are occasionally due to the nasal conditions that give rise to the affections of the nasal sinuses.

Unexplained cases of circumscribed, and even disseminated choroiditis, have followed after no other history of ill health than a preexisting tonsilitis, or disease of the naso-pharynx (de Schweinitz). The relationship of pyorrhea alveolaris to uveitis has been frequently observed. Nettleship called attention to carious teeth as the only apparent cause of certain cases of plastic choroiditis that he had treated. Fish, of New Orleans, maintains that the etiological factor in uveitis is very frequently to be found in a passive orbital hyperæmia due to nasal sinus diseases. Senn and Sprigg have maintained a relationship between cases of itido-choroiditis and an atrophic nasal catarrh. Ziegler makes recurring iritis dependent upon nasal conditions.

I am now treating a patient for a septal necrosis following a traumatism. There are no positive signs of sinus involvement, but there is certainly an effect upon the eyes, such as slight photophobia, weak accommodation and lacrymation, when trying to read, but no inflammation, congestion, or even hyperemia, is apparent. In this case, as in so many, there are uncertain features. For instance, in the course of the last several years she has had double iritis, appendicitis, peritonitis and pelvic abscesses, in the order mentioned. This is a pretty good picture for syphilis, but we find that the peritonitis and abscesses followed the leaving of a dressing in the wound when operated for appendicitis, which reduces the value of our evidence considerably.

In Dr. Dowling's very-much-diseased 18 months old second case, with the varying degrees of lens opacity, at first there was vision, dim, but positive; after a pneumonia there was blindness, and with physical improvement there was a return of the previous amount of dim vision. The essayest does not say so, but I fancy he had considerable difficulty in satisfying himself as to these degrees of vision. However, every positive contribution calculated to clear hazy etiology is of value, and this merit is present in the paper.

GEORGE W. MCDOWELL: I have noticed for a long time in connection with phlyctenular conjunctivitis and diseases of the nares, particularly, a contact between the terminals and the septum, and I have in recent years referred a great many of these cases to the Throat Department of the Ophthalmic Hospital for more thorough examination and treatment than we can give in the Eye and Ear Department, and with very beneficial results as regards the recurrence of the phlyctenular trouble. I would like to ask Dr. Dowling whether, in the case in which he operated on the maxillary sinus with immediate relief of pain, he found a great deal of pus?

DR. DOWLING: Yes.

JOHN L. MOFFAT: I have one case in mind that I saw a number of years ago, the first case in which I ever noticed a connection between the nose and the ear. This occurred before I had seen anything in any of the literature about the relation of the nasal

troubles to the ear. There was a recurrent injection of the conjunctiva, large venous blood vessel, horizontal, in the nimbus of the eye. That was very obstinate. If I recollect rightly now, it came back upon straining the eyes, also upon catching cold or exposure to smoke or dust. We could do nothing with it until the nose was operated on for a large middle turbinal body. The case was operated on and passed on to a cure, and I have not seen the man for years. That was quite a number of years before I saw anything in the literature about it.

J. IVIMEY DOWLING: I make reference to the nasal nerve, and it is the nasal nerve, to my mind, that is largely accountable for many of these ocular effects being complicated by nasal conditions. It is lodged in the cranial cavity, then enters the orbit through the sphenoid fissure, then passes through the orbit to the inner side, giving off the long ciliary nerves; then enters the cranial cavity again through the anterior ethmoid cells, then passes along the dura mater and enters the nasal cavity; then is continued as three distinct branches, anterior, internal and external. The external branches are restricted to the anterior end of the middle turbinate and inferior turbinate, and judging from experience, I think the film is also attributable to the sinuses themselves; that is, the ethmoid cells entering the maxillary sinuses. That is the way I trace the relationship, largely. I did not emphasize that in the paper as much as I would like to.

THE CLINICAL SIGNIFICANCE OF CILIARY NEURALGIA.

FREDERIC G. RITCHIE, M. D.,
NEW YORK CITY.

The subject of this paper is one that appeals primarily to the general practitioner, and it was in his interest that its preparation was undertaken by the writer.

In presenting it for your consideration, it is with the idea that its contents should be suggestive, rather than exhaustive, as it would be manifestly impossible in such a paper to give a complete symptomatology of the various phases of the many diseases of which ciliary neuralgia is one of the manifestations; but I trust that the brief symptomatology here presented, together with any additional symptoms brought out in the discussion which may follow its reading, may present a mental picture sufficiently comprehensive to be of material assistance in enabling one to arrive at the probable exciting cause in any given case, and thus permit us to better conserve the welfare of our patients and avoid a course which might

reflect upon our professional skill and work irreparable injury to the patient. If this result be attained, the paper will have accomplished all that its writer could have wished.

Upon an examination of the literature bearing upon ciliary neuralgia, I was much surprised at its paucity, and particularly at the space (or rather the lack of it) devoted to its consideration, in the standard text books and works of reference treating of diseases of the eye. Not a single author of those works which I examined made more than a mention of it as a symptom of some ocular affection.

In order that we may not start with a false premesis, let us first consider what we understand by the term "ciliary neuralgia." In its broadest sense it is any pain of a severe, paroxysmal character, occurring along the course of the distribution of the first or ophthalmic division, and those branches of the second or superior maxillary division of the fifth nerve, which supply the lid, temple, forehead, cheek and side of the nose. It may or may not be associated with neuralgic pains in parts supplied by its other branches, and is not infrequently accompanied by occipital or cervico-occipital neuralgia.

Ophthalmic herpes zoster is usually preceded by severe neuralgic pains, confined to the distribution of the ophthalmic division of the fifth nerve of one side, although the second and third divisions are occasionally involved at the same time. The eye may be involved later during an attack of herpes frontalis or infraorbitalis, but it is especially liable to complicate a neuritis of the nasal branch.

The attendant symptoms are pyrexia, loss of appetite, and chills. After a period of from one to ten days a vesicular eruption, upon an inflamed base, makes its appearance over the distribution of the affected nerve. The vesicles may vary in size from a pin's head to that of a split pea, and at first contain a yellow fluid which becomes brownish, and at the end of a week's time dry up and fall off, leaving more or less numerous characteristic, disfiguring scars. The neuralgia is persistent, and the more so the older the individual, sometimes lasting when all other traces of the disease, except the characteristic cicatrices, have disappeared; indeed, it has been known to persist for years. There is also anæsthesia of the affected area.

The eye lesions comprise swelling of the conjunctiva with the possible formation of vesicles; vesicular eruption on the cornea, which breaks down leaving ulcers, or results in sloughing of the cornea and involvement of the iris and ciliary body. One or more of these ocular lesions may be present except in very mild cases, in which the only symptoms observed may be photophobia, lachrymation and slight congestion of the eye. There may be present a tenderness over the lachrymal gland.

The disease has been mistaken for erysipelas, but it may be easily differentiated by the following characteristics: The local disturbances are limited strictly to the distribution of the fifth nerve; it occurs on one side only, never passing the median line; the vesicles are more numerous and smaller than those of erysipelas, and do not

spread when once developed; and finally, that the adjacent lymphatics, as a rule, are not involved.

Neuralgia of the lachrymal gland (dacryoadenalgia) is characterized by severe paroxysmal pain in the region of the gland, excessive lachrymation and photophobia. It may assume a chronic character and is liable to recur. It is a rare affection, and has been observed in children, in women during pregnancy, and in gouty subjects.

Acute inflammation of the lachrymal gland (acute dacryoadenitis) presents, in addition to the symptoms enumerated in speaking of dacryoadenalgia, redness and edematous swelling of the upper lid and conjunctiva, the latter often covering the cornea. The swelling is most pronounced in the region of the gland, while the enlarged gland may displace the eyeball downward and nasally, and greatly restrict its movements, which are accompanied by pain. Resolution may take place, or the affection may go on to suppuration, which may point either through the integument of the lid or in the superior conjunctival cul-de-sac. One or both eyes may be affected. The diseases with which it may be confounded are erysipelas, purulent conjunctivitis, and orbital cellulitis.

Ciliary pain occurring during any affection of the cornea means that there is added to the existing corneal lesion either a spasm of the sphincter muscle of the iris, or a congestion of that structure which may rapidly progress to an actual inflammation. These pains are only present in deep-seated or infected cases, and extend in a radiating direction over the forehead and side of the head, and even downward along the side of the nose and over the cheek. They are usually worse at night, and are relieved by the instillation of a mydriatic, provided the iris is not adherent so as to prevent dilitation of the pupil. If such a condition exists, the pain will persist in spite of the use of the mydriatic.

These pains must not be confounded with the superficial variety, which are of a burning, scalding or smarting character, similar to that experienced from the irritation of a foreign body, and which yields to a local anæsthetic, such as holocain.

Among the *superficial diseases of the cornea* in which ciliary neuralgia is a prominent symptom, may be mentioned keratitis dendritica (which may be either idiopathic or appear during the course of pertussis, intermittent and typhoid fevers, bronchitis, pneumonia and influenza), keratitis vascularis, keratitis bullosa, keratitis filamentosa and infected ulcers.

All the *deep forms of keratitis*, except those of an asthenic type, are accompanied by more or less ciliary pain, and when severe in character, and marked by nocturnal aggravations, indicates an involvement of the ciliary body.

The retrogressive stage of the ulceration of the cornea is marked by a diminution in the intensity of the ciliary pain as well as of the congestion, photophobia and lachrymation, yet one must be on his

guard and not be lulled into a sense of security, for there is amelioration of these symptoms, and even complete subsidence in cases of grave ulceration which have changed in type from the sthenic to the asthenic.

A *staphyloma of the cornea* which is attended by suppurative inflammation due to exposure to the air and the irritating particles of a mechanical, chemical and infectious character suspended therein, and also a staphyloma that is unattended by any inflammatory symptoms may have as an accompanying symptom ciliary neuralgia; in the latter case the pain will be due to entanglement of the corneal nerves in the cicatricial tissue, or to a complicating iridocyclitis or glaucoma.

Small *cicatrices of the cornea resulting from traumatism* occosionally give rise to ciliary neuralgia which persists for months and is intractable to the usual methods of treatment. The pain is periodic in character, often appearing in the morning and lasting one or two hours. It is probably due to entanglement of a terminal filament of a nerve in the cicatrix.

Involvement of the cornea during the course of *acute trachoma* is attended with neuralgic pains in the brow and temple, in addition to the other signs of corneal involvement, such as intense photophobia and lachrymation.

Anterior scleritis, when implicating the underlying ciliary body, will be accompanied by more or less ciliary pain and other symptoms of ciliary involvement. A circumscribed area of the sclera near the corneal margin appears of a bluish hue, and becomes raised above the level of the surrounding portion, forming a staphyloma of more or less prominence. This stretching and thinning of the scleral walls is accompanied by pain and the other symptoms referred to, and the morbid process may even invade the adjacent corneal tissue.

There may be one or a number of nodules, which in the latter case may form an irregular chain about the cornea.

The disease, at its inception, might possibly be mistaken for a gumma of the ciliary body, but the latter would have been preceded by an iridocyclitis, and the color of the ectasia would be red and fleshy-looking, instead of bluish.

There is an *intermittent, transient form of scleritis* which appears suddenly without any apparent cause. There is an acute hyperemia of the conjunctival and episcleral tissue, and there may be a slight œdema of the lids accompanying a severe ciliary neuralgia and profuse lachrymation, simulating the symptoms of a beginning iritis, but a careful examination shows the iris to be normal. The attack passes off in from a few hours to three or four days. Relapses are frequent, and the attacks may follow at intervals of a few weeks or months. Both eyes are rarely affected simultaneously, although the attacks may alternate between the two eyes.

Pain of a neuralgic character, which is usually worse at night, is a marked symptom of the plastic and parenchymatous forms of

iritis and *cyclitis*, and its severity may be out of all proportion to the objective symptoms of the disease. It may vary from a "bearable" pain confined to eyeball and brow, to that of agonizing intensity, which may extend to the temple, side of the head, nose and cheek, and may even involve the upper teeth. The other symptoms present are photophobia, lachrymation, and ciliary injection, which latter is distinguishable from a conjunctival injection by the deep-seated rosy zone, of greatest intensity close to the cornea, and by the fact that pressure exerted through the lids does not affect it, while the conjunctival injection is composed of superficial vessels which are easily emptied and are movable under pressure transmitted through the lids, and is most marked in the region of the superior and inferior cul-de-sacs.

When the ciliary body is involved, the color of the pericorneal injection takes on a violet hue.

It is true that in severe cases of iritis and cyclitis there is a conjunctival injection as well, which may make it somewhat difficult to appreciate the deeper injection; but if pressure is made through the lower lid at the corneo-scleral junction while the lid is slowly depressed, if the injection is confined to the conjunctiva a white streak will momentarily be left, which will gradually be obliterated by the refilling of the conjunctival vessels; while a ciliary injection, if present, will still remain, unaffected by the manipulation. To the above enumerated symptoms we must add a sluggish action of the pupil to the light-reflex, which in advanced cases may amount to immobility from an engorgement of the vessels of the iris, spasm of the sphincter pupillæ, or adhesions of the iris to the capsule of the lens. The surface of the iris lacks lustre and has a woolly appearance, and by comparing the affected with the unaffected eye, we will notice a change in the color of the iris, a blue iris taking on a greenish, and a brown a yellowish tint.

Plastic and parenchymatous iritis or cyclitis may be confounded with acute glaucoma, and inasmuch as the treatment of the two conditions is radically different, the patient might suffer irreparable loss of vision as a result of a mistaken diagnosis. They have a number of symptoms in common, such as excruciating pain in and about the eye, swelling of the conjunctiva and lids, and intense ciliary injection, with marked diminution of vision. The following symptoms will, however, serve to differentiate the two affections. In iritis or iridocyclitis the pupil is contracted, unless a mydriatic has been instilled, which fact should be inquired into; in glaucoma, the pupil is dilated, unless there are adhesions from a precedent or concurrent iritis, or unless the pupil has been contracted by the use of a myotic; in iritis the tension of the eyeball is normal or slightly increased at the height of the disease; in glaucoma the tension is markedly increased; in iritis the anterior chamber is normal or increased in depth (due to adhesions of the posterior surface to the capsule of the lens); in acute glaucoma the anterior chamber is shallow; in

iritis the cornea is sensitive to touch; in glaucoma it is anæsthetic, and frequently presents a stippled or slight ground-glass appearance.

Mydriatics, which are called for in iritis, are contra-indicated in glaucoma, and if used will result in an aggravation of the disease and a possible loss of the eye within twenty-four hours.

Panophthalmitis, or acute suppurative inflammation of the eyeball, is usually due to the direct introduction of septic matter into the eyeball as a result of penetrating wounds, operations involving an opening of the ball, and infected ulcers of the cornea.

It is characterized by severe ciliary neuralgia, general febrile disturbances, inflammatory swelling of the lids, chemosis which is so great that it frequently protrudes between the lids, haziness of the cornea, turbidity of the aqueous humor (which is later replaced by pus), swelling of the tissues of the orbit, causing proptosis, until the lids and eyeball may attain the size of a Tangerine orange.

It may be mistaken by the uninitiated for erysipelas of the lids, but an inspection of the eye, together with the history of the case, will clear up the diagnosis.

Sarcoma of any portion of the uveal tract may give rise to ciliary neuralgia, either from direct implication of the ciliary nerves or from pressure due to a glaucomatous process.

Acute retrobulbar neuritis, which fortunately is of rare occurrence, runs a rapid course, producing partial or complete blindness in a few hours or days, from which recovery may be complete or partial in one or more months. It is usually bilateral, but may affect but one eye, in which case it is usually the left.

The accompanying symptoms are severe pain in the eyeball and back of the eye, extending to the forehead and sides of the head. In monolateral cases the pain is confined to the corresponding side of the head. Movements of the eyes, particularly in the lateral directions, are attended with pain. Slight pressure on the globe causes the patient to shrink on account of the pain produced. If the vision is much affected the pupils will be dilated and fail to react to light, or such reaction will be feeble.

The ophthalmoscopic symptoms are not pronounced, as a rule, being confined to a slight discoloration of the disc with over-distention of the vessels, although there may be a slight neuroretinitis or even a choked disc. It, however, shows no hemorrhages, but simply a thin line of extravasation at its upper and lower borders.

There is also a subacute form accompanied by pain in and behind the eye, and which is augmented by movements of the eyeball and by pressure upon the globe.

Neuralgic pain is among the most frequent of the subjective symptoms of *refractive errors,* and may manifest itself in any of the various regions supplied by the tri-facial nerve. It may occur after the use of the eye as a result of excessive strain, but is of more frequent occurrence in individuals whose muscular or nervous system is below par, as during convalescence, at the menstrual period, following

temporary exhaustion from excessive mental or physical exertion, or when the system is suffering from the retention of the products of faulty metabolism.

Hypermetropia, with spasm of the ciliary muscle, may give rise to distressing ciliary neuralgia, which is aggravated by any work requiring close application of the eyes. The pain usually follows the distribution of the ophthalmic division of the tri-facial, being frequently referred to the back of the eyes, and, in neurasthenics, to the occipital regions as well. The pain may not be neuralgic over the entire regions mentioned, but, on the contrary, the patient complains of a dull aching in the forehead, extending to the vertex, temples and occiput, with a distinct sharp pain in some localized area, frequently above the brows. These pains, at first, only manifest themselves after prolonged use of the eyes; for instance, they may come on during the evening after an excessive demand upon the ciliary muscle following a hard day's work. Gradually, however, the intervals of relief from pain become shorter, until finally the slightest use of the eyes may suffice to precipitate an attack, and the patient is only able to struggle through his day's work by repeatedly closing and making pressure upon the eyes, or resting them frequently for short periods of time.

Myopia is less prone to give rise to the class of symptoms just enumerated, but on the other hand they are a frequent accompaniment of myopic astigma.

Astigmia, whether hypermetropic, myopic, or mixed, is probably responsible for the vast majority of headaches of the neuralgic type, and the smaller the degree of the astigmia the more likelihood is there of its producing serious discomfort. This is particularly true of those cases in which the axes are obliquely situated.

Exophoria, or a tendency of the visual lines to diverge, is frequently manifested by pain in and around the orbit, and which makes its appearance after using the eyes for near vision for an hour or so. Patients suffering from this form of heterophoria will frequently complain of pain at the inner angle of the orbit, or a sharp sticking pain in the inner sides of the eyeballs. Intense cephalgia, or hemicrania accompanied by vertigo, double vision, nausea and vomiting, are not of infrequent occurrence. Such patients will frequently complain of difficulty in adapting, or as they express it, "focusing" their vision for points at successively varying distances within twenty feet. On excluding one eye from vision, however, the symptoms disappear.

Esophoria and hyperphoria also give rise to pains of a neuralgic character in and about the eye, but as a rule they are referred to remote parts, and do not show the tendency to localize themselves in adjacent parts as do those accompanying exophoria.

Neuralgia, due to *cyclophoria*, is usually attended by vertigo and nausea, and like all symptoms caused by anomalies of the extrinsic ocular muscles, continues as long as the use of both eyes is persisted in, but vanishes when the affected eye is excluded from vision.

As in refractive errors, so in muscular imbalance, it is the smaller errors which are usually attended by pronounced nervous disturbances.

The *hysterical form of asthenopia,* with ciliary neuralgia, in which the pain is usually located above the brows and at their junction, differs from the neuralgia accompanying asthenopia due to refractive and muscular errors, in that it appears after a few minutes' use of the eyes, and not after prolonged use. If the patient persists in the use of the eyes, the pain becomes very acute, spreading over the head and even extending to the neck and shoulders. Another point is that the pain is not necessarily coincident with the use of the eyes, but may be provoked by fright or any violent emotion. Burning pain is complained of, and is especially aggravated by light; sometimes it is sunlight, and again it may be artificial light. Disease of the left cerebral hemisphere in the neighborhood of the third frontal convolutions has been demonstrated in several cases.

Paralysis of the extrinsic muscles of the eye, when due to causes located within the orbit, may vary from a slight paresis to a complete paralysis, and from that of a single muscle to involvement of all. This form of paralysis is usually attended by pain about the eye, which is provoked by any attempted movement of the eyeball, and when caused by an orbital cellulitis or tenonitis, we also elicit pain upon pressing the globe backward into the orbit. In tenonitis, the chemosis, if present, is slight, while in orbital cellulitis it is pronounced; the exophthalmos in orbital cellulitis is much greater than that caused by a tumor of the orbit. A certain degree of anæsthesia of the integument of the frontal region is present in a considerable portion of these cases, due to an implication of the internal and external frontal nerves. If the history discloses an exposure to cold preceding the paralysis, and frontal and circumorbital pains, together with pain on movement of the eye, the affection is probably of rheumatic origin.

Severe neuralgic headache limited to the side of the involved nerve, usually precedes attacks of *recurrent third nerve paralysis.* The pain is frequently accompanied by nausea, vomiting, rigors and a feeling of general malaise, all of which symptoms disappear upon the advent of the paralysis, which is often sudden. The affection is a rare one, and is more frequent in childhood or youth, and in the female sex. As a rule, all the branches of the third nerve of one side only are involved, and the recurrence is confined to the same nerve. The interval between the attacks may vary from ten days to a year, but the tendency is toward a gradual decrease. The paralysis may last from three days to several months, and indeed, it may not disappear completely during the interval between the attacks. The disease may be purely functional, or in rare instances may be due to a lesion of the nerve trunk at the base of the skull.

Acute syphilitic osteoperiostitis of the orbit presents the following symptoms: Intense pain (which may be periodic) in and about the

orbit, most marked in the brow, which is sensitive to pressure. The pain is worse at night, and if the tumor is large, or if it is situated deeply within the orbit, it will give rise to exophthalmos, which will be in line with the direction of the swelling. Constitutional symptoms, such as pyrexia, nausea and vomiting, anorexia, etc., are present in cases involving the cellular tissue of the orbit. The tumor is generally flattened and of considerable breadth, and if its location is such that it may be reached by the finger, it will present an unyielding resistance to pressure. A growth presenting the before-mentioned characteristics, and situated external to the margin of the orbit, and over which the integument is inflamed and adherent, is either a periostitis or a gumma; in the latter case the tumor will be elastic to the touch.

Acute periostitis is more likely to be a manifestation of the early stage of syphilis than is the gumma, while both chronic periostitis and gumma are usually confined to the late stage of the disease.

In the chronic form of the disease, the inflammatory symptoms are few and inconspicuous, and it is only late in its course, and when situated near the orbital margin, that the objective symptoms are manifest. We then get a swelling which is recognized as being located on the bony wall, together with an edematous swelling of the surrounding soft parts; the tumor itself is resistant and sensitive to pressure, and exhibits a slight indistinct fluctuation. There may be proptosis and slight neuralgic pains.

Periostoses of the orbit if situated near the exit of the supra or infra-orbital nerve, will give rise to a neuralgia of the regions supplied by the affected nerve, and which is more or less constant, and tends to increase with the extension of the affection. They also cause neuralgic pains when they press upon the eyeball or upon the nerves within the orbit. When situated at the apex, causing pressure upon the ophthalmic division of the fifth, the pain is deep-seated and may be referred to the brain, simulating a cerebral tumor or a meningitis; it will be still more misleading if the pressure of the tumor causes a papillitis or an atrophy of the optic nerve.

Serous tenonitis, orbital cellulitis panophthalmitis and thrombosis of the cavernous sinus, present common symptoms, of which pain in the ophthalmic division of the tri-facial is one. Panophthalmitis, however, is attended by suppuration within the eyeball, which is disclosed on inspection, and which is not present in the other three diseases mentioned. They present in common the symptoms of œdema of the lids, chemosis, protrusion of the eye, and marked interference with the motility of the eyeball. In the earlier stages, tenonitis and orbital cellulitis are difficult to differentiate, but the proptosis is less marked in tenonitis, as is also the pain on movement of the eye, while the chemosis and the restricted movement of the eyeball is much greater. In orbital cellulitis the protrusion of the ball is excessive as compared with the chemosis, which is most marked in the region of the opening of the lids, and the febrile disturbances

and the pain are more intense; in fact, all the symptoms increase in severity until the pus is evacuated. In tenonitis, on the other hand, the symptoms soon subside until the eye becomes normal.

Thrombosis of the cavernous sinus is differentiated by the accompanying boggy œdema over the mastoid region, together with symptoms of intracranial pressure.

Retraction of the eyeball, with periodically recurring neuralgia of the fifth nerve, has been observed.

Sudden severe pain in the orbit and head, which may be coincident with a sensation as if something had given away inside the skull, and followed by a continuous roaring or buzzing sound, which increases in intensity, may mark the *rupture of the internal carotid artery or one of its coats, in the cavernous sinus,* or may be due to an *aneurism of the ophthalmic artery.* It may be idiopathic, or may follow a fracture of the base of the skull, or a penetrating wound. After a few hours or days, the lids commence to swell, there is an œdematous swelling of the conjunctiva with distention of the veins in which the blood is of a deep red color; the eye is protruded, but may be returned to its normal position by firm pressure, only to protrude again when the pressure is removed. There is a visible pulsation of the eyeball, apparent on careful examination, and a thrill in addition to the pulsation, which is rythmical with the pulse, is imparted to the fingers on palpation. There may be a pulsating tumor which, if present, is usually located at the upper and inner angle of the orbit, and which imparts a distinct thrill to the fingers. If the stethescope is applied over this region, it will disclose a blowing or whistling murmur which is continuous, but accentuated with each cardiac impulse, and is materially reduced or inhibited by pressure over the common carotid of the corresponding side. The retinal veins are enormously engorged and the hearing may be impaired.

Any *tumor of the orbit* may, by pressure upon one of the branches of the trigeminus, give rise to a ciliary neuralgia. Cysts of the orbit, with the exception of the congenital variety, are almost invariably accompanied by ciliary neuralgia. It is a more constant symptom of those due to *echinococci.* The most important symptoms are exophthalmos (the direction depending upon the situation of the growth), impaired motility, and an elastic tumor in which may be detected fluctuation. Vision is seriously impaired from pressure which causes a papillitis or an atrophy of the optic nerve. Having excluded encephalocele, a puncture will enable us to differentiate between this variety and a dermoid cyst. The fluid does not coagulate on boiling, and the addition of nitrate of silver causes a white, cheesy precipitate. Microscopic examination may reveal the presence of heads or hooklets.

Severe cases of *trichinosis* may involve the eye, causing œdema of the lids, pain, loss of motility and exophthalmos.

A reported case of *filaria* in the vitreous was attended with photopsia, severe pain, central chorioretinitis, and partial detachment

of the retina. The site of the worm was marked by an opacity of the vitreous, anterior to the macula, and about the size of the disc, in which was detected an independent movement.

Acute frontal sinusitis gives rise to pain of a neuralgic character in the supraorbital region, which sometimes radiates in various directions. It is usually worse in the morning from nine to eleven o'clock, and shows a marked periodicity. It increases in severity for an hour or so, and then remains unchanged until midday or later, when it gradually decreases in severity until it disappears in the course of the afternoon. There is a sensitiveness to percussion over the frontal eminence, and pain on pressure over the exit of the supraorbital nerve, and also over the floor of the sinus at the upper and inner angle of the orbit. The pain in the eye is aggravated on blowing the nose. The relief from pain is usually coincident with a discharge of muco-pus from the nostril of the affected side. The affection may, by extension, cause caries of the walls, and open externally through the brow, or extend to the orbit, giving rise to an orbital abscess; or resolution may take place with a subsidence of the symptoms.

An affection of the sphenoid sinus is more liable to give rise to pain in the occiput or vertex, although it not infrequently manifests itself in the supraorbital or temporal regions. Anterior rhinoscopy will generally reveal pus between the middle turbinal and septum, while the rhinoscopic mirror will disclose the presence of pus high up on the nasopharyngeal wall, and in the upper part of the posterior choana. Should the exit to the discharge be blocked, the pressure symptoms will be exaggerated and the spread of the infection may be indicated by sudden blindness (which may be more or less complete), exophthalmos, or possibly thrombosis of the cavernous sinus, or a fatal basal meningitis.

Pain, if present in *ethmoiditis*, is usually referred to the back of the orbit or to the eyeball and in severe cases to the infraorbital region and temple. The middle turbinal is enlarged, and there may be a slight swelling of the external nose and cheek of the affected side, with redness of the skin over the lower border of the orbit. There is present a more or less profuse discharge of pus from the nostril of the affected side, which may have an offensive odor. The sense of smell is usually impaired or lost. If the discharge does not make its escape through the natural channels there may be proptosis, impaired movement of the eyeball, diplopia and even blindness. The disease may extend to the orbit or give rise to a leptomeningitis.

Canfield reports a case of neuralgia confined to the ophthalmic division of the fifth nerve, of two and a half years' duration, characterized by paroxysms of extreme intensity which increased in severity and duration. The first symptom noticed was an occasional slight twinge of pain confined to the tip, alæ and right side of the nose, extending later to the cheek, brow, and forehead, with a bor-

ing pain in and behind the eyeball, which persisted in spite of all treatment. These regions were sensitive to touch, and slight pressure on the tip of the nose caused severe pain deep in the orbit. Rhinoscopic examination was negative, except that the middle turbinal was in contact with the septum over an area of a quarter of an inch. Removal of the anterior and middle portion was followed by the discharge of a red gelatinous mass and the subsidence of the symptoms. Another case of eight years' standing with paroxysmal attacks of pain in the nose, face and upper lip, was relieved by treatment directed to an enlarged middle turbinal. Still another case presenting identical symptoms which had persisted for an equal length of time, was immediately relieved by the removal of a bony hypertrophy of the middle turbinal.

A case of intense ciliary neuralgia accompanied by proptosis and diplopia, with a T+1 in the right eye, and presenting a mild papillitis and haziness of the vitreous, was cured by curetting the ethmoid cells. A second somewhat similar case was cured by the removal of a portion of the inferior turbinal.

Severe pain referred to the eyeball, frontal region and temple, with intense photophobia and lachrymation, and marked congestion of the inferior cul-de-sac, following an attack of acute rhinitis, disappeared after evacuating a quantity of muco-pus from the anterior ethmoid cells.

In *antral empyema*, pain is an almost constant symptom, unless there is free drainage. It is referred to the cheek, brow, and often to the ear of the affected side. It is paroxysmal in character, short in duration, and its advent as well as its cessation is abrupt. The teeth feel elongated and are sensitive to percussion. The gum and inside of the cheek are swollen, as well as the roof of the mouth on the affected side; there is pain on percussion over the affected area, and a sensitive point over the exit of the infraorbital nerve. An abundant yellowish discharge with a bad odor, which is perceptible to the patient, and which is increased on hanging the head downward, issues from the nostril of the affected side.

Tumors of the antrum give rise to an infraorbital neuralgia with a bloody nasal discharge. They usually escape diagnosis until they cause bulging of the antral walls or extrude after breaking through. Polypi or cysts readily give rise to hemorrhage upon slight injury. Malignant growths give rise to spontaneous hemorrhage, while this symptom is rare in benign tumors as is also the neuralgic pains when the growth of the tumor is slow.

In all suspected cases of sinus involvement one should avail himself of the information to be derived from a transillumination of these cavities.

Dental irritation, due to caries, exostoses, exposure of sensitive dentine, ulceration of the gum, injuries coincident to extraction, irritation from fillings, or a misplaced wisdom tooth, may give rise to ciliary neuralgia, and that, too, without the offending tooth being the seat of any pain.

Basal meningitis, in addition to other ocular symptoms dut to pressure upon the optic tracts or commissure, may involve the fifth nerve, giving rise to pain which is referred to the regions supplied by it, or such regions may show loss of sensation, depending upon whether the pressure is such as to cause irritation or to inhibit the function of the nerve.

One of the prominent symptoms of *dengue or break-bone fever*, and also of *yellow fever*, is acute supraorbital pain which is aggravated on moving the eyes. This symptom, as well as the frontal cephalgia, brilliancy of the eyes, and the congestion of the conjunctiva and the lumbar pains, are common to both diseases. Of course, icterus of the conjunctiva and sclera, if present, will aid materially in differentiating the diseases in the earlier stage.

Exophthalmic goitre, in some cases, presents as one of its peculiar and trying symptoms paroxysmal attacks of severe pain in the eyes, accompanied by profuse lachrymation of a scalding character.

The local use of eserine in the eye is not infrequently followed by ciliary spasm and pain, which is so severe as to necessitate the discontinuance of its use.

Influenza presents at its incipiency an acute conjunctivitis which is a direct extension from the nasal mucosa. In the same manner, the lining membranes of the accessory nasal sinuses are involved, resulting in a ciliary neuralgia which may be referred to one or more of the regions supplied by the ophthalmic and superior maxillary divisions of the tri-facial. The neuralgic pain is accompanied by the other symptoms of irritation which have been mentioned when speaking of diseases of the accessory sinuses.

Hajec avers that he has never seen a case of trigeminal neuralgia following influenza, except in the presence of an accessory sinus involvement of an acute origin; and Kopetzy says that pains of a neuralgic character following influenza should be viewed with suspicion and carefully studied before a diagnosis of neuralgia is made.

Hubbard cites a case of a girl of sixteen years with a history of an aggravated case of ozena of years' standing, who contracted influenza. There was excruciating frontal pains, a temperature of 103° F, and pronounced restlessness. After the seventh day there occurred rigors, vomiting, strabismus, retraction of the cervical muscles, followed by death on the tenth day, and which he attributed to empyema of the frontal and probably ethmoid sinuses, followed by a purulent meningitis.

Ciliary neuralgia of malarial origin has been reported by some writers, but recent authorities seriously question the etiology, attributing it to an existing acute, or an acute aggravation of a chronic sinusitis.

DISCUSSION.

E. I. BISSELL: Dr. Ritchie has given a very complete synopsis of ocular and nasal diseases, which at times may be accompanied with ciliary neuralgia. He has done the work so well that I cannot add to the list enumerated.

I trust I may be pardoned if I suggest that there is danger of confusing the general practitioner in attempting to emphasize one symptom in some forty or more diseases—some very rare, and many so obscure as to require special instruments of precision in the hands of experts to make a differential diagnosis. However, the paper has great value in forcibly suggesting that the etiology of ciliary neuralgia usually cannot be determined without a thorough examination of the eyes and nose. If this thought is carried away from the meeting, some cases may be saved from partial or total blindness, and many others from severe pain unnecessarily prolonged.

GEORGE W. MCDOWELL: Personally, I can add nothing to what Dr. Ritchie has stated in his paper, except to express the feeling that we will all have a much greater respect for the eye and its possibilities than before.

J. IVIMEY DOWLING: I would just like opportunity to cite two cases which were brought to mind by Dr. Ritchie's paper, which, by a little stretch of the imagination, are apropos, because they were cases of supraorbital neuralgia confined to the right side, starting at the notch just over that region; but there was no vesiculation at all. One of those cases was a child of ten or twelve when we first saw it, and that condition continued for about a year. Finally, I determined that there was a movable hard substance at the right region of the supra orbital note. I suggested that by operation we might possibly discover something there which impinged upon the nerve, and in that way might relieve the neuralgia. They acquiesced, and I dissected down and removed a little calcareous deposit. Every time the child would close the lids it would apparently stretch the nerve and cause the pain; had the pain frequently, sometime during the day almost every day. That is more than a year now, and there has been no recurrence.

Another case was a woman of about fifty-five years of age. She gave a history of having had neuralgia, continuing for some months, which was sequent to an injury caused by the falling of the lid of an ice chest, which struck her upon the eyebrow. I tried various things; prescribed glasses and various other methods, but without relief. Finally the thought came to me that she might have fractured the supra orbital foramen, and caused some trouble to the nerve. I suggested that to the patient, asked that I might operate, and she acquiesced. I found that the foramen had been fractured, causing a pressure upon the nerve. I dissected about half an inch of it. About six months have passed, and the patient has had no

trouble since, except, of course, the lack of sensation which would naturally follow. I thought, Mr. Chairman, those were cases well worth speaking of.

JOHN L. MOFFAT: We owe Dr. Ritchie our thanks for this paper, and I hope he will supplement it by what he did not have time to give us—indications for the remedies. The most valuable publications we have are monographs, and if the Doctor will fill this out by giving the treatment suggested by the ciliary neuralgia in these cases, especially the Homeopathic indications, he will produce a work of great practical value. I hope to see it some day.

I want to thank him also for getting on the band wagon by adopting the term *astigmia.* This is coming, despite Dr. George M. Gould who, in a strenuous conversation this summer, said he was too busy saving eyes by correcting the prescriptions for glasses made by other doctors, to change his dictionary in a matter of "mere etymology."

There is one thing I want to speak of in connection with the paper. Ciliary neuralgia, if accompanied by increased tension of the eyeball, may be probably due to glaucoma. Has anyone present had cases of ciliary neuralgia in glaucoma simplex, when there was no increased tension? I feel that I have allowed myself, for twenty-five years, until within this last year, to associate high tension too closely with glaucoma; and that I have overlooked some cases of glaucoma because I did not find increased tension of the eyeball at the moment or moments when I saw the patient. Now, is the ciliary neuralgia due only to the increased tension when the eyeball is too hard? I would like to have the discussion reach that subject if there is any experience on it.

REPORT

OF THE

BUREAU OF LARYNGOLOGY AND RHINOLOGY.

"Sinuses as Routes for Infecting the Meninges and Mastoid," - - - - - - - - - RALPH I. LLOYD.
"Hay Fever," - - - - - - - - - - JOHN B. GARRISON.
"How to Blow the Nose," - - - - - - - FRANK B. SEITZ.
"The Relation of the General Practitioner to the Specialist in Diseases of the Nose and Throat," - - JOHN W. LE SEUR.

THE NASAL SINUSES AS ROUTES FOR INFECTING THE MASTOID AND MENINGES.

RALPH I. LLOYD, M. D.,
BROOKLYN.

The Board of Health of the greater city refuses to accept the diagnosis of simple meningitis. They require a cause and a good one. They will accept infection by tuberculosis or the germ of spotted fever or the transference of infection from mastoid or other abscess in and about the skull. Yet there are cases in which the extreme rapidity of the disease and the absence of prodromal symptoms make the diagnosis of tubercular meningitis very doubtful; and the absence of spots and spinal involvement has the same effect so far as cerebro-spinal fever is concerned. The question then arises, "Where did the infection come from?" These cases are of several types, and I will try and hastily report a few. A child takes cold; its nostrils are blocked for several days and the discharge is very profuse. One side of the nose seems decidedly worse than the other. On this side an ear-ache develops, the drum rupturing very early. The discharge is profuse, but the fever does not subside; the child looks very sick and complains of headache. Examination at this time results as follows: Child has a haggard expression, complains of shooting pains in the head, awakens with a start. Temperature 102. Pulse 120. Slight tenderness over the mastoid. Profuse discharge from canal; no sinking of the upper posterior wall near the drum; good opening in drum in lower posterior quadrant. The mastoid is opened. A little pus in the antrum, but no bone destruction. No necrotic areas. Patient dies in thirty-six hours, with pronounced meningeal symptoms.

Child has a cold for several days, no fever. A very slight earache with moderate rise of temperature. A small area at the highest part of the drum is congested. The earache lessens and suddenly the symptoms of meningitis appear and the child dies in two days.

A case was reported in Philadelphia recently very much like the first one, in which the mastoid was thoroughly cleaned out; next the ethmoidal sinuses were similarly treated, and after death an autopsy failed to reveal any route whatever by which the infection might spread. I have approached this subject as an Aurist, hence the ear is prominent in the cases I mention. But Dr. Palmer, who will lead the discussion, will no doubt report cases in which there were no ear symptoms. It may be said that if you have an infected nose, it is easy for that infection to reach the ear; once in the ear, it is easy to reach the brain. Some authorities have reported defects along the canal of the seventh nerve in the middle ear, and believe that in some cases the spread from ear to brain is explained. Others say that in the type mentioned first, in which there is a slight localized redness of the drum, there is a local infected inflammation on the roof of the middle ear, and that the infection travels right through the bony partition and infects the meninges.

Taking all of the different cases together, it seems to me that the lymphatics are responsible for some of these cases. Such being granted, what connection between ear, brain cavity and nose can be demonstrated? I can offer only a very little light on the subject. That there is an intimate relation between the diploe of the mastoid bone and sphenoidal sinus, can be very easily shown. A funnel is fastened into the diploe of the mastoid bone and an air outlet attached to the cut surface of the occipital bone. The whole bone is then incased in plaster of Paris. Fusible metal with a melting point of 125 degrees F. is poured in the funnel. The whole bone is placed in an oven and kept at 180 F. for four hours. The plaster is removed, and the bone placed in hydrochloric acid to remove the lime salts. A strong solution of lye destroys the animal material, and this cast is the result. The petrous portion of the temporal bone does not connect, lymphatically speaking, with the great wing of the sphenoid anteriorally, nor the body internally. With the occipital posteriorly, there is just one place where the metal runs across, and that is where the jugular process of the occipital articulates. In this way, there is an unbroken chain of lymph spaces in the interior of these bones running from the mastoid into the occipital, thence into the body of the sphenoid, and finally into the sphenoidal sinus itself. This can be readily seen in the cast.

I am more familiar with the diseases of the ear than those of the nose, and can say that conclusions based on the arrangement of these cells about the ear in the interior of the bone, as demonstrated by this method, have been borne out by clinical experience.

Whether the conditions about the nose are different, remains to be demonstrated. Meningitis is a disease that we reasonably cannot

hope ever to cure; rather should we endeavor to prevent it. So far as the mastoid is concerned, it looks as if the ear and nose specialists must get together more. Perhaps in the future, it will be the habit of the general practitioner to examine every nose carefully when the patient complains of a simple cold, instead of prescribing only; and maybe attention early, to acute sinus infections, so mild that their symptoms are no worse than those of an ordinary cold, may lessen the number of cases of meningitis.

DISCUSSION.

JOSEPH HASBROUCK: From the standpoint of the specialist, meningitis can never be cured. I tell you, gentlemen, that we have a history of Homeopathy for seventy-five or eighty years, and I have had an experience of thirty years, and I say right on this floor that meningitis can be cured, and tubercular meningitis can be cured. If any of you younger men will get Testes' Diseases of Children, and some of the older writers, you will find that not only plain meningitis, but tubercular meningitis was cured. I have seen two cases of tubercular meningitis cured within three months, absolutely, just as certain cases of tubercular meningitis as any diagnosis could make them. I did not find the germ there, but from all the conditions there was tubercular meningitis there; and I believe meningitis can be developed in the system without a bug getting in through the ear-drum of the nose.

GEORGE A. SHEPARD: Five years ago, when I was in Germany, I saw Dr. Jansen operate upon the antrum; and after cleaning out the antrum he said, "I think it is a good plan to examine the sphenoid sinus"—not that there were any symptoms; and in cleaning out the sphenoid sinus he removed a polyp, very foul, that was nearly three-quarters of an inch long, as large around as my finger. The man seemed to be in perfect health, except for the local disturbance in his antrum. This led me to feel that a great many cases of meningitis were undoubtedly due to extension from the sphenoidal sinus. It is, of course, an extremely delicate operation, and possibly more people will be killed in the common examination of the sphenoidal sinus than in allowing the disease to go on; yet it is something that we ought to keep in mind. That case was one that could not have gone on but a little while without death following positively yet the symptoms were absolutely nil in reference to the sphenoidal sinus.

RALPH I. LLOYD: It is rather difficult to say when you cure a case of tubercular meningitis. Our old school brethren have cited cases in which the symptoms ceased without very much medication. Therefore, it is a question whether such a serious ailment could be cured.

RHINITIS VASOMOTORIA PERIODICA.

JOHN B. GARRISON, M. D.,
NEW YORK CITY.

A condition so frequently met with, and which causes such a great amount of trouble and suffering, seems to be worthy of some consideration at this gathering, and in bringing this paper before you it is not so much to teach you anything that you do not know concerning it, as it is to endeavor to draw from you in the way of discussion, practical points in the way of treating this annually recurring disease.

Hay fever has been recognized for many centuries, but I believe that Bostock first brought it prominently before the medical world in 1819. Since that time it has occupied a portion of the stage each year, and many have been the attempts to discover a method of treatment that should be a specific; but while many have been more or less successful, none have been able to cover all cases; proving that the individuality must be dealt with.

We all know of the varying types met with in practice, and of the different causes. In May or June we have it appearing in connection with the roses that beautify our land, while in the latter part of summer we find it coincident with the pollen of the "rag weed," golden rod, and other flowering plants. We all have been astonished to learn that patients afflicted with hay fever are, many of them, able to predict with almost absolute certainty the month and day that their infirmity will appear, so precise in its action is the nervous organism. There are, however, many cases appearing independent of pollen or other air-borne irritants, for which we must look to a variety of causes. A neurotic habit seems to be provided for most of the patients afflicted with hay fever; in some, so delicate is their nervous organism, that it requires very little to tip the scale, while in others a greater amount of irritation is borne before the trouble is noticed. In one case we find, upon examination, an enlarged turbinal; in another a spur which seems to be altogether too small and insignificant to be the cause of the present condition; in the third we see a middle turbinal which seems at first to be normal in size and appearance, but on closer examination we find a point so sensitive that the slightest contact with the probe is sufficient to cause intense pain. Sometimes the accessory sinuses are found to be diseased. Writers have at times laid great stress upon the condition of uricacidaemia, which they claim to be a causative factor of no mean importance.

It is noticed that in cases which have presented symptoms for a number of years, there is a liability to have an extension of the symptoms from the upper to the lower respiratory tract, and it is

also noted that in these cases the termination of the attack is not so abrupt on the appearance of frost, but has a tendency to more gradually subside, while any local irritation is apt to provoke a renewal of the symptoms.

For the first few hours when the attack is appearing, there is a feeling of dryness, fullness and itching of the nose, vault of the pharynx and the inner canthus of the eye, but these are of short duration and soon give way to violent paroxysms of sneezing at intervals which are always shortened by exposure to dust or sunlight. The eyes weep constantly; the nose seems to be connected with an inexhaustible reservoir of watery fluid, and the mucosa soon becomes so swollen that breathing through that organ is impossible. Headache, particularly in the frontal region, is apt to be present, and it may be more or less severe throughout the whole head. Itching along the eustachian tube, with a feeling of pressure and fullness in the ears is a frequent accompaniment and impairment of the hearing is likely to follow in time. Constitutional symptoms are likely to vary with the individual and the severity of the attack. Asthmatic symptoms seem to be the natural outcome of repeated attacks, and in later years will persist both day and night, so that the patient, if not cured in the early years, is likely to become a confirmed asthmatic.

The treatment may be simply preventive. Send the patient to some immune spot, like the ocean, for a long voyage, or perhaps to the White Mountains, taking care to have him go some days before the attack is due. This will give the patient immunity for that season, but in no way attempts to effect a cure. Or, examine for nasal abnormalities and remove the bony spur; the fibrous synechia; the hypertrophied turbinate; the polypi or other causes of irritation that are possible factors in the production of the condition in question. This method may prove curative, and in some cases undoubtedly will. We will do well, however, to think of the wondrous power of Homeopathy and to study the patient, independent of the mere symptoms shown during the attack, and, by finding all the peculiar symptoms, apply the remedy that is best to the constitutional habits of the individual. The nervous system is accused of being at fault in a large number of the cases we meet, so why not expect to get results by using remedies that are indicated? The Allopaths have already discovered that the administration of the ambrosia artemesifolia affords an immunity in some cases when it is given for a time previous to the advent of the pollen of the ragweed, and if we do not want them to come in and eventually rob us of our heritage, it will be well for us to give more attention to our homeopathic methods in the strictest sense of the term. I do not mean that we should neglect to employ surgical means where they are needed, nor should we neglect to enforce the sanitary or ditetic measures at our command; but with care, Homeopathy may be curative in more cases than we can believe, unless we have tried

them faithfully. I plead guilty to the charge of not having tried as carefully as I might to find the remedy indicated in these cases, but yet I have seen a single dose of bryonia cut short an attack when, from the violence of the symptoms, we might reasonably expect it to run a course of many days, at least. The case I speak of commenced by having the characteristic nasal and pharyngeal symptoms of dryness and fullness; thirst very marked; agg. from all motion; eyes sensitive to daylight, and a cough that seemed to tear the trachea every time it occurred. There was a history of previous attacks lasting for many days before relief was obtained, but here a single dose of the remedy produced an amelioration in a few hours, and it was not interfered with, but allowed to act, and in three days the patient was well and attending to business. Let us hear of your experiences.

DISCUSSION.

W. S. SEARLE: I would like to say that if anyone wants to cure hay fever, he must cure the tendency to it in the system; but he can prevent it and relieve it almost at once by the use of a vegetarian diet exclusively. Since I have tried this for four or five years, I have not failed in a single instance, beginning a month before the expected attack, putting the patient on a simple vegetarian diet; and in many cases no return of the hay fever has been experienced, and in others a very, very slight recurrence, and all are very much relieved.

JOSEPH HASBROUCK: I think there are three legs to stand on. One is individual susceptibility, another is specific poison, and the third is the temperature of the location that the patient is in. I have had considerable experience in treating hay fever, and am free to claim that I have cured a good many cases. I have one man who was subject to it thirty-two years ago. When I went to Dobbs Ferry I cured him the first summer, and his is the ragweed type. Now I do not have to give him more than eight or ten doses of arsenicum 30, and he is freed from it for that year; and possibly if he gets into the ragweed again, he would have to take a few more doses of arsenicum 30. It is not a germ, it is not a pollen, that causes the disease, always. I have a very interesting case of hay fever that I am observing now. The first year I thought he got it from ragweed. I gave him the ragweed tincture, and helped him a little. The next year he got rid of hay fever pretty well, went up in the country, playing in the golden rod, and came down with hay fever and had a very severe attack. Last year we sent him up somewhere in New Hampshire, in the White Mountain region. There was ragweed and golden rod there, and he just literally played and skipped and lived in them without any more hay fever than he has in the middle of the winter. The last gentleman who spoke has the idea that we can prevent hay fever by diet. I have read about

everything I could hear of; I have read Dickey on Hay Fever, but the best and most intelligent thing I have ever got hold of is Fanning's. He is a Philadelphian who was a hay fever sufferer himself. He has the thing down to a dot, and if any of you want to know how to manage hay fever, you will get more information from Fanning than from anything else I have ever read.

C. E. TEETS: I believe, with Dr. Garrison, that you have to study each case separately. I have been treating hay fever now for about thirty years, and have come to the conclusion that I do not know anything about it. I have operated on quite a number of cases, of patients who had been suffering for years, with perfect relief. After a period of five or six years they have had no return of the attack. And I have operated in a number of cases in which there has been very little relief. I have tried certain remedies, and some cases have been benefited, while in others there have been no results whatever. There are a great many cases that are relieved by the use of this ambrosia of Curtis. While on my vacation this summer, in Yarmouth, I met a number of people, two who had been going there for the last ten years, who had been great sufferers, and they told me that since they had come there, about June, they had had no trouble whatever; no symptoms whatever of hay fever. So it shows that the climate must have some effect upon the sensitive mucous membrane. I will be glad to pay very liberally anybody who will give me a sure cure for hay fever. I will make the donation a thousand dollars.

CHARLES MCDOWELL: I would like to mention colantin, a German remedy, made in two forms, the spring and the fall variety. One is from the rye and the other, I fancy, from ragweed. It is used in both powder and liquid forms, and is dropped in the nose. It was brought to my attention a year or more ago by a patient who had suffered from hay fever of the spring variety for many years, and he claimed that it gave him very great relief. I have used it in two or three cases since with moderate benefit. I would like to hear the experience of others present.

ELIZABETH W. M. CAMERON: Natrum muriaticum is the best thing I have ever tried, and sabadilla. I have generally found more relief from natrum muriaticum than anything else. I use it high; never use anything lower than 200.

CHARLES E. PAINE: I had one case this summer in which I tried colantin, the fall serum, the powder form. The patient has usually had the fever come on about the twentieth of August every year. I gave the colantin with directions to sleep in a closed room, which seems to be the particular thing to recommend—that the patient shall sleep in a room which has practically no ventilation; the windows all closed; the colantin to be taken in the morning before rising, and snuffed up the nostrils. It seemed to relieve the patient quite a little; in fact, kept the hay fever off for about a week or ten days, and when it came on it was not nearly so severe as in previous years.

JOSEPH HASBROUCK: The disease coming on a little later depends on the season. Several of my cases are always attacked on the 10th of August. They didn't have it until the 1st of September this year, and then it came on just the same. The season in the country is about two weeks later than usual, and if the hay fever appears two weeks later, it will be on time.

WILLIAM M. BUTLER: I would like to ask some of these men who know all about it, why it is that these people who are subject to hay fever will go for perhaps five or ten years to a place where they have no recurrence of the disease, and thereafter the properties of that place seem to wear out for them, and they have the fever just as much there as anywhere else; and why is it that people on the ocean do not have hay fever? Is it on account of there being no pollen there, or is it owing to some quality of the salt water? Anybody in going to Europe, finds every year, on every steamer, a crowd of people that make it a habit to go every year, simply because they are free from hay fever. I do not think I have ever been on a steamer that did not have someone taking the trip to prevent hay fever. If it is the salt air, why could not something be done in the way of a salt spray, or allowing the patient to breathe salt air on land?

JOSEPH HASBROUCK: I cannot answer that question, but I can ask another. Why is it that a given remedy will cure hay fever one year, as I have it do repeatedly, in a number of cases, with perfect success, and when I have prescribed the same remedy the next year it would not do the same patient any more good, not as much good, as salt water? Natrum muriaticum cures catarrhal cases, or the mucous cases, where the discharge runs clear from the nose, but when you get a real Simon-pure catarrh, natrum muriaticum does not touch it.

ELIZABETH W. M. CAMERON: Try it high.

JOSEPH HASBROUCK: I have tried it pretty high. Fanning takes up all these questions and then tries to answer them. He was a sufferer from hay fever of the worst form, and has had a great deal of experience with it. He gives the remedies, all the way from the tincture of iron to the thousandths dilution of pulsatilla, and he says that sometimes pulsatilla 1000 is just the thing for certain conditions. He is very liberal with his potencies, and he gives the tincture, and gives Epsom salts. He thinks when the attack is coming on, a good dose of Epsom salts will clean house and relieve the attack as well as anything else, and he gives pulsatilla 1000 and natrum muriaticum 1000 when the indications are for them.

HOW TO BLOW THE NOSE.

FRANK B. SEITZ, M. D.,
BUFFALO, N. Y.

It might seem, on first thought, that an apology were necessary for presenting before such a body a paper, the title of which would indicate that it is very elementary; but after many years of special work, I unhesitatingly state that not one person in a hundred knows how to, or does, blow the nose properly, and that if the nose were properly, freely, strongly blown and cleaned in the way nature provided, that great bugbear—catarrh—would soon be a thing of the past. In fact, I will go further, and state that not only would hearing be better preserved and improved, but the lung capacity enlarged, with all that that implies.

To obtain such a welcome relief from those annoying ailments in so simple a manner seems preposterous; but I will call your attention to the fact that simplicity has been the solution of most great problems. It was long known that the eustachian tubes carried air to the middle ear, as demonstrated by Eustachius. It was realized by Valsalva that to blow air into the tubes improved hearing, but it was reserved for Politzer to give us his simple method of inflation. Cataracts had long been variously and unsuccessfully treated until Von Grefe gave the simple knife. Suppuration had long been the bane of surgeons until Lister killed sepsis. It was a simple nose-blow that revealed the law of gravitation to Sir Newton, and so forth, ad libitum.

City people inhale a lungful of dust and soot-laden air eighteen times a minute, day and night, year in and out. What becomes of the dust? We know the normal nose has enough space for air to pass through freely, and enough glands to secrete mucous to moisten the air and collect the dust. If not blown out daily, it mixes with mucous which thereby becomes thickened, flows less freely and is apt to collect more dust, and also plugs the orifice of the glands. There is a stasis of the glands and circulation, which, if long continued, results in our well-known hypertrophy, with its sluggish response to varying temperatures and humidity. This happens, remember, in what was a normal, but unblown nose.

Now add some spur, ledge or shelf which deflects the air current, so as to form a whirlwind in some of the many nooks and crevices, deposit its solids, and we soon have a breeding place for an empyema. A shelf is a beautiful eavestrough upon which dust, mixed with thickened, sluggish mucous, flows slowly, steadily and annoyingly backward, downward, drop by drop into the pharynx.

Let us consider a nose where one or the other either alternately or, worse, both nostrils are constantly closed to the free passage of

air, and we have a pitiable condition, indeed. No incoming air to dry secretions, air passing down the throat unmoistened by mucous, unsifted of its ashes and we soon have an irritable bronchi. Later there is the same stasis of glands and circulation we had in the nasal mucous membrane. There is a thick, gluey mucous coating those air cells not forcibly opened by deep breathing—and here again is where a good deep breath to thoroughly blow the nose has one of its many beneficial effects—the cells soon become glued together, and we have a mass of substance containing some unchanged foul air, some unchanged mucous, and we have established an inviting summer resort for Mr. Tuberculosis.

Not one of you who does nose work but has observed the tiny, delicate, unobtrusive and futile imitation of a nose-blow on the part of nine-tenths of your patients. Many give a slight expiration, and satisfy their conscience by a fussy wiping of the ali nasi and an expression of annoyance. You have, no doubt, noticed that most frequent style of (not) blowing the nose where the deluded one starts to blow one side, and as soon as the current has begun to flow, suddenly checks it by closing that nostril and releasing the other. The other, however, to be as suddenly checked as soon as the good work begins. Such a nose-blow is *per se* not a nose-blow at all.

There are some who are accustomed to draw the breath back through the nose, hawk and spit, and consider that a clearing of the nose; and they complain of having catarrh! Much more excusable is a child. It seems to blow the soft palate against the roof of the pharynx, closing the posterior end of the nose. There is a puffing of cheeks, a burst of saliva, and frequently a burst of tears, when all efforts to blow, or to teach to blow, must be abandoned. Moral: Teach the children to blow their nose, but first learn how to properly do it yourself.

Every act has an object in view, and the object of blowing the nose is to clear it from superfluous mucous, which in most cases is cast off, or gushed out, because of offending particles; just the same as nature will send a gush of tears when even the most minute particle of substance enters the eye. It seems to me the proper procedure is to cover the hand with your handkerchief, either single or double ply, according to the expected quantity or its fluidity.

Say we are using the right hand—to begin right is a good beginning—place the thumb tightly against the side of the right nostril, the four fingers forming a pocket just below and in front of the left nostril. Now take a very deep inspiration, then blow the contents of both lungs in a strong, steady, uninterrupted stream through the left nostril, meanwhile keeping the right tightly closed. Next close the left with the four fingers, release the right by raising the thumb, take a deep breath as before, as full as the lungs will hold—and here is where we will soon get complete expansion of the smaller lung cells—then blow long, strong, steady, as before, until almost all the air is exhausted from the lungs. A long blow will

compel you to refill the lungs with renewed, revitalized and re-oxygenated air. It is my humble opinion that a nose-blowing "hour" should be in the curriculum of every school, just as there is now a few minutes for exercise.

This subject has been so frequently brought to my attention that I considered it worth presenting; and will add that while a simple, inexpensive method, it will, if fully carried out by patients, result in a much better nose, a much better throat, a much better lung and, of course, a very much better, healthier, happier patient.

DISCUSSION.

C. E. TEETS: Mr. President, I think the paper is a very good one, and I agree with Dr. Seitz that many people do not know how to blow the nose.

H. WORTHINGTON PAIGE: Do you agree with his directions?

DR. TEETS: I am not sure, but I think I do. I know there are many people who will grasp the nose, and instead of the mucous being forced forward, it is drawn backward and sometimes forced into the eustachian tube. I do not believe, as many aurists do, that douching the nose very often sets up inflammation of the ear. I do not believe the inflammation is caused by the water getting into the tube, but by the mucous being forced into the tube by the water, or by blowing the nose improperly. I know I always instruct my patients to blow the nose in a certain way. I tell them not to grasp the nose in this way (indicating), but to hold the handkerchief under the nose, first closing one nostril and then the other. In that way there is no danger of getting mucous back into the tube. I think the idea is a very good one, and I agree with the Doctor that if more children were taught how to blow the nose properly, there would be less trouble with the ears.

PRESIDENT SCHENCK: I would like to speak of one point that was not brought out in the paper, and that is the faulty manner in which mothers hold a child's head when it is required to clear the nose. The mother will come along, seize the child by the top of the head and pull its chin up in the air, bringing the nose into the highest position and then ask the child to blow. Of course, the tendency of all fluids is to gravitate into the throat. That is a very common fault with mothers, and one of the reasons why so many adults get into incorrect habits in blowing the nose is oftentimes because mothers give such a bad example to them in their youth, and they simply do not know how.

REPORT

OF THE

BUREAU OF MATERIA MEDICA.

"Materia Medica Symposium—Reports and Discussion of Verification of Symptoms," - - - - - VARIOUS AUTHORS.
"Cantharis in Acute Nephritis and Endocarditis," - - WALLACE MCGEORGE.
"Medorrhinum," - - - - - - - - - WILLIAM HAZEN FREEMAN.
"Comparison of Solanacæ," - - - - - - - E. WILTON BROWN.

INFANTILE PNEUMONIA.

B. L. B. BAYLIES, M. D.,
BROOKLYN, N. Y.

A. R., age 14 months, has crepitant respiration posteriorly; tubular breathing below the right clavicle, dullness on percussion in the scapular and infra-scapular regions on both sides, most pronounced on the right side; cough painful, more frequent while recumbent, sleep lying on the abdomen, moaning during sleep; cough awakes her, crying.

I found correspondent to sleep lying on the abdomen and cough during sleep, belladona, calcarea and stramonium. Belladona was given without benefit, but the symptom, cough during sleep, had been erroneously given me; cough awoke the child, was accompanied by crying; and to this were added sleeping with the eyes partially open, moaning during sleep, grinding the teeth, distended abdomen, offensive flatus; green, undigested, forcible discharges, and putting the feet out of cover of bed. Distension of the abdomen with offensive flatus was comprised by twenty-three medicines. Of these grinding the teeth was represented by arnica, bryonia, calcarea, arsenic, lycopodium, mezereum, phosphorus, sepia and sulphur. All of these have undigested stools. Uncovering the feet in bed is characteristic of sepia and sulphur. Moaning in sleep, the forcible alvine discharges, the *tout ensemble*, emphasized sulphur. A dose dry of sulphur 200th was given on the third day of treatment; of the 1000th of sulphur B. and T. on the fifth day; on the tenth day a dose of the millionth Fincke. The temperature, which had run from 101 degrees to 105.4 degrees, decreased under the

treatment, and gradually thoracic resonance and normal respiration returned in both lungs, at first more fully in the right lung; sleep and other functions became normal.

The little girl convalescing from the tenth day, was removed to the country on the twelfth day—July 15th.

The case was attended by much prostration. In the latter days of her illness, clusters of itching pimples appeared on the nates, and a few on the face and other parts of the body. Recovery was complete.

A CLERGYMAN'S SORE THROAT.—Rev. L. W. S., a public speaker of largely developed brain, is subject to attacks of sore throat, affecting the fauces and larynx, hoarseness, and at intervals partial aphonia; literally, "clergyman's sore throat."

There is diffused inflammation, with swelling and shiny redness of the tonsils and palate, which have a rather dry appearance, although the saliva is increased; the margins of the tongue are slightly indented, no fœtor of the breath. He is somewhat better while lying on the abdomen, and sleeps in that position; better also by external pressure on the throat; disposed to frequent swallowing; when swallowing, rawness in the throat and sticking pain in the left ear; can swallow solids easily, saliva or spittle with difficulty. Indentation of the tongue and salivation pointed towards mercurius. Mercurius iodatus had apparently no beneficial effect after twenty-four hours. Both mercurius and belladona have aggravation by swallowing saliva or spittle; both have sticking or boring pain in the external and internal ear, but belladona is most markedly relieved by external pressure. Of the two remedies, it alone is better sleeping and lying on the abdomen, and also has this peculiar symptom mentioned by the patient, which I quote as italicized in the Cyclopedia of Materia Medica: *"Now and then, while speaking, the voice which has been weak, becomes suddenly loud and clear."* Belladona 200th in solution q. 3h. relieved him in a few hours, and cured promptly, as he gratefully acknowledged by letter.

NEURALGIA OF PREGNANCY.—Mrs. E. P., a sensitive, mildly emotional woman, in the sixth month of pregnancy, has intermitting, stinging, shooting and drawing pain in the left temple, extending to the cheek; better from local application of heat, by hard pressure, and continued motion. Severe pain obliges her to leave the bed and walk about in the night; the tongue is moist, coated on the right half only.

Stinging, shooting and drawing pain in the tempero-maxillary region, relieved by hard pressure, by warm wrapping, and continued motion, correspond to china, rhus and sepia. To rhus, which as also the semi-coated tongue, the symptoms correspond in the highest degree. Two doses of rhus tox. one thousandth B. and T. were given dry at six-hour intervals.

The first dose immediately relieved, the second temporarily aggravated. Prompt recovery followed without further medication.

THUJA AND HEPAR IN UTERINE FIBROIDS.

W. W. BLACKMAN, M. D.,
BROOKLYN, N. Y.

Early in April, 1905, I was called to see Miss A., aged 37, tall, spare, dark hair, gray eyes and of a decidedly nervous temperament.

She had just recovered from a severe attack of malarial fever in consequence of which she was greatly debilitated. In addition to this she was suffering from an abdominal growth, which had been diagnosed by two other physicians as uterine febroma, and my opinion was sought as to the advisability of an immediate operation. Owing to her depressed vitality, I advised against it.

The growth in question was hard and firm to touch, movable with the uterus, to which it was attached by a broad base, projected a little more to the left of the median line, and reached nearly as high as the umbilicus.

She presented the following history: During childhood she enjoyed ordinary good health, but she had never been well since she began to menstruate. During her entire menstrual life she had been subject to frequent and profuse hemorrhages, either from the uterus or from the nostrils. Up to her 27th year her menstruation was always irregular, too frequent, and very profuse.

Any unusual physical exertion or any mental or emotional disturbance would bring on the hemorrhage.

The flow was dark, clotted, and stained the guard almost indelibly; seldom accompanied with pain, but on the contrary, in spite of the loss of blood, she felt better and slept better during its continuance. In the intervals between the uterine flow she either had attacks of profuse bleeding from the nose, or diarrhœa.

At the age of 27, ten years before I saw her, she had a period of uninterrupted uterine flow which lasted nine months, during which time she was confined to the bed. Since then, she has menstruated more regularly, although the period has been of ten days' duration, and the loss of blood excessive. She had been for many years under the care of a Homeopath, a skillful prescriber and an acute observer, and it was with extreme reluctance that I undertook to prescribe a remedy for her.

The fact that the treatment she had been having had proved a little more than palliative, led me to conclude that there was some underlying constitutional condition, a sycosis, dyscrasia, or call it what you will, but a something which had not been reached by most careful prescribing.

Boenninghausen says in an article on "Thuja as an Intercurrent Remedy," 'many chronic affections of the worst character prove intractable under our best remedies, and show no signs of improve-

ment until recourse is had to a remedy which has the power to act favorably upon a disease of a sycotic character.' Furthermore, he asserts that Thuja is the great anti-sycotic remedy.

Accordingly, the patient was given three powders of Thuja (200) with directions to take one every third night. Within ten days she developed, on the forehead and chin, a firey red, papular rash which was rather sensitive to touch. This was a source of great annoyance to the patient, who asserted she had never had a rash before.

She was given a placebo. One month after taking the Thuja she seemed stronger; there has been no loss of blood from any source. The tumor was perceptibly smaller, but no change in the rash on the face. No medicine. In June, the tumor still smaller, no flow, rash on the face the same. Repeated the prescription of Thuja and waited six weeks. At this time the tumor was reduced more than one-half; still no menstruation, or nosebleed since Thuja was first given in April; but the patient's general condition was not good. She was debilitated and thinner, and was having frequent attacks of diarrhœa. The stools were thin, fœcal or watery, aggravated during the day, after eating, or drinking cold water, which caused colic. She was very sensitive to cold; felt cold all the time; only on the warmest days in August was she comfortable, and even then wore a jacket when she went out. Hepar (200) night and morning for six days. Patient went to the country at this time, but I received a very favorable report about September 1st. She was feeling better in every way; bowel trouble had entirely ceased, less sensitiveness to cold, and was stronger. No medicine.

I saw her again about the middle of October, and she had gained weight, was stronger, no sensitiveness to cold, rash on face entirely gone. No menstruation.

On bi-manual examination the tumor could be barely felt at the pelvic brim. I examined the patient again about January 1st, 1906, and the tumor could not be found. After an absence of more than eight months the menstruation had returned, but was normal in quantity, and lasted five days.

From that time to the present writing she has menstruated for a period of five days, once in every twenty-eight, and to all appearances is perfectly well.

DISCUSSION.

W. H. PIERSON: The paper of Dr. Blackman has been a revelation to me, and I think very probably the next case of fibroid I get I shall try hepar; but I think I can go him one better, if you will pardon the citation of a case, that of a lady about 34 or 35 years of age, that had a fibroid—and by the way, the Doctor does not say whether his was a sub-serous, a sub-mucous, or an interstitial case. This was a sub-serous case, and the tumor was probably the size of

a good-sized teacup. On account of certain conditions it was inadvisable to operate. The case was so diagnosed by three different men. High saline irrigations at a temperature of 110 were given twice daily continuously for six months. The examination of last week revealed the growth to be perhaps the size of an English walnut, not larger. There has been no medicine given, nothing but the saline irrigation. I thought that case was worthy of reporting.

JOSEPH HASBROUCK: The last case was cured by natrum muriaticum, also the psychotic remedy, and she absorbed it. I remember a case I had a great many years ago, when I did not believe in the high attenuations. It was an old lady, 72 or 73 years of age. It was in 1884. I remember it distinctly, because she was the mother of one of those who helped build the new aqueduct, as we called it at that time. She had a large fibroid tumor that protruded from the vagina. It was peduncular, and I said the best thing to do was to take that off. She said, "You won't take it off of me. I am 74 or 75 years old, and if you can't cure it in any other way, it is going to remain there until I go to the other side." So I injected it a few times with about the first dilution of thuja, and gave her thuja 30 internally. I never made but one prescription. I injected it probably three times, and the thing began to shrink. She kept on taking the medicine. I saw her about four years afterward. She was still living, and the tumor was gone. You couldn't find it.

I remember another case of a very old woman with the same result. I injected that with about the first or second dilution of thuja. I did not measure particularly. I took a few drops of thuja and put it in water, and gave her thuja 30 internally. Thuja 30, natrum muriaticum and natrum sulphuricum are all psychotic remedies, and I believe the last case reported absorbed the growth.

W. H. FREEMAN: Cases with results like those spoken of by Dr. Blackman always arouse a certain amount of skepticism; a great deal of skepticism, in fact, especially on the part of men who are not competent to select and use remedies in this way; and for that reason, I think anyone who has had experience along these lines should give it. I have had no occasion to remove any fibroids as yet, although I have treated a good many of them, and treated them with very good results. I have had, though, in my own experience a case of epithelioma of the uterus, which was so diagnosed by Dr. Walter C. Wood and Dr. J. Hubley Schall, of Brooklyn, and which was diagnosed by the microscopist as an epithelioma of the womb, each one of the three consultants stating to the family that the woman would have to die inside of six weeks, and probably inside of two or three weeks; absolutely no cure and no help for her. I told the family I thought she could be helped with homeopathic remedies. During the treatment, which extended over a period of about a year and a half, and which consisted principally of sepia, but of a great many other rem-

edies used inter-currently also, this growth disappeared entirely. I sent the patient down to Dr. Wood about a year ago, with a letter explaining the circumstances, and stating that I thought he would be interested in again examining the case. He wrote me a very nice letter in reply, stating that it was the most remarkable case he had ever seen, and that he knew of no way to account for the result except as an act of Providence. I had not said in my letter anything about the Homeopathic treatment, because I thought it would be a waste of words. But as soon as that woman began to get sepia she began to improve. The improvement was so quick, so marked and so unmistakable, that it could not be ascribed to anything else. The woman had been failing gradually for quite a long time. When I called to see her she was in such a condition that it was hardly necessary to make an examination. You could diagnose the condition with your nose. You could smell it as soon as you got into the house. She had been having profuse, dark-colored and very offensive hemorrhages almost constantly for six or eight weeks before beginning treatment; and within a few days after giving her the first dose of sepia 200, the flow ceased entirely. That woman is perfectly well to-day, so far as any subjective or objective signs of disease are concerned. I have examined her frequently in the last couple of years, and I know positively regarding these facts.

W. S. SEARLE: It seems to me it is well, once in a while, to look at the other side of the shield, and not to be too sure about our recoveries being "cured." I want to just narrate an instance that occurred to Dr. E. P. Fowler, of New York. One spring a lady called upon him with her daughter. They were old patients of his. The daughter had discovered a tumor in her breast. Dr. Fowler examined it and it was very suspicious to him. He sent for Drs. William S. Bull, R. S. McBurnie, and Allan McLane Hamilton. The three of them examined the case, and they all pronounced it malignant cancer, and said it must be operated on. The lady did not want to have the operation until fall, because they were arranging to go to Europe, but before she went away she mentioned some uterine symptoms, and Dr. Fowler thought it best to examine her. He did so, and found nothing, but he did not say so. He asked them to come again in a week. They did so. The mother said, "Doctor, I don't know what application that was you made to my daughter, but it has had a fine effect. The tumor is smaller and not so painful, and is softer. I wish you would make that application again." He did so. It was simply the introduction of the finger. Three introductions were sufficient to cure that case entirely. Now, there are multitudes of cases of that kind. We are all too prone, I think, to consider that we cure, when the patient "recovers."

A CASE OF MANIC DEPRESSIVE INSANITY CURED BY ARSENICUM ALBUM.

WILLIAM MORRIS BUTLER, M. D.,
BROOKLYN, N. Y.

When clearly indicated, no symptoms of our materia medica are more reliable than the mental. The following case of manic depressive insanity, which I treated in the Middletown Homeopathic State Hospital the first year of its establishment, illustrates the curative effects of arsenicum album in mental disease.

The history, as recorded in the case book of the hospital, is as follows: Charles V. B., aged fourteen, was received October 12, 1874, from the Institute for Deaf and Dumb, New York city. November 21, 1868, was run over by a tender of a locomotive, receiving severe injury at the base of the skull. While in the institution became feeble and emaciated; pulse 56 to 60, weak, irritable and wakeful fore part of night. Ten days previous to admission here (Middletown Hospital) grew rapidly worse. Had hallucinations of sight, taste and smell; thought there was a hole in the crown of his head and that bugs constantly crawled out of it and over his body; also imagined that he saw, smelled and tasted the bugs which were in and about his person. Attempted several times to get out of the window, with the view of committing suicide; threatened to kill himself with a knife; imagined that he was soon to die, and that the daily papers were commenting on his case. October 14th. Tearful and in constant fear of being killed. October 17th. Shows more signs of fear; puts up his collar to hide his face, and cries. Slept fairly. R. arsenicum album 12th. October 19th. Cries less; says there is a soft spot on his head; smells, tastes and feels bugs. October 20th. Greatly disturbed; says his head is hot, and hurts on top; wants to prevent spiders from coming out on the top of his head; says he had better commit suicide if he cannot be cured immediately. October 22d. Less excited, but same delusions. October 26th. Mischievous and obstinate; delusions decreasing. November 10th. Restless and full of delusions. October 11th. Excitable delusions, worse at night. November 21st. Says nothing about bugs. November 27th. Improving. ℞. arsenicum 30. December 3d. Seems nearly well; medication discontinued. Discharged soon after, recovered.

This is an extremely interesting but pitiable case. Patient was deaf, dumb and insane, belonging to a family in which there were three other deaf mutes and several more of near kinship. Yet in spite of the apparent disadvantages in the case, the patient was permanently cured, receiving but two potencies of one remedy.

DISCUSSION.

DR. BUTLER (continuing): The other cases I have to mention occurred in the Homeopathic Hospital on Cumberland street. We have a large number of alcoholic cases there. One night one of the internes telephoned me that a case of alcoholism had been received and was very much excited; would not get into bed because there was another person in the bed. I telephoned back to him to give the man petroleum 200. The man was given that remedy, which quieted him down and removed the delusion very promptly, so that within forty-eight hours the man was in his normal condition.

Another case I had there was an alcoholism, a very violent and dangerous patient. He had to be kept in restraint in a jacket, and tied to the bed most of the time on account of his violence. The chief characteristic of his violence was his tendency to bite, and that is one of the marked characteristics of cantharides. If you went near this man he would jump at you, as far as his restraint would let him, bite at you, bite the pillow case, bite the sheets or anything he could get his teeth into. Under cantharides 30 he made a prompt and permanent recovery.

WILLIAM H. FREEMAN: I have had considerable experience in conditions where there was suicidal tendency, mental depression, etc., which I have been able to relieve with arsenic; and I can verify the remarks of the gentleman who preceded me as to the curative value of remedies in potency. When I say "cure" a case with a certain remedy or a certain potency, I do not mean that the case "gets well." I mean that a case that would not otherwise get well, and is not getting well; that has been sick for weeks or months and is getting steadily worse, begins to get well as soon as it gets the remedy. Now, one isolated case counts for nothing; half a dozen cases do not amount to anything; but where you are seeing from fifteen to thirty patients day in and day out, and are having this kind of experience all the time, every day in the year, and with ninety-five per cent. of your cases, what are you going to ascribe the results to? Speaking now of chronic cases, especially cases considered incurable, cases that do not get well of themselves, cases that are going down hill; cases, possibly, that are dying; cases that have been given up by other physicians to die—I am curing most of them with the homeopathic remedy, chiefly in the high potencies. I do not say I cure them all. I meet a case occasionally that I have not brains enough to solve, and cannot untangle; but the majority of these cases can be cured, if the physician will only study them properly, and only give the right remedy, and not be afraid to use the potency. If we will prescribe scientifically and in an up-to-date manner, we will cure nearly all these cases with these potencies.

JOSEPH HASBROUCK: I would like to add to what Dr. Freeman says, get the remedy and give one at a time. Then you know where you are. If you give arsenic and bryonia together, and the patient

gets well, you do not know that the arsenic did it at all. If you give arsenic and rhus together, you do not know that the arsenic did it. I think the greatest humbuggery in prescribing is where you give two or three remedies at once.

ARNICA—WHEN INDICATED—COMPARED WITH ANTISEPTICS.

D. E. S. COLEMAN, Ph. B., M. D.,
NEW YORK.

To the true follower of the homeopathic law, what seems an extraordinary cure is simply the general rule with his treatment; and unless there is some special incident, like the failure of "old school" methods, it passes by unheeded as an ordinary every-day happening.

The following case, a simple one to a Homeopath, is one of those which is of interest as a comparison of methods.

Mr. X., age seventeen, had first, second and third toes of left foot crushed in a press, necessitating an amputation.

April 15, 1907. Operation performed. Wound dressed with bi-chloride of mercury 1-10,000. Morphine was given at night for the pain, which it absolutely failed to relieve. The flaps seemed too short and no healing resulted; instead three unhealthy ulcers marked the sight of operation.

The following treatment was followed for over three months with absolutely no result:

April 18th. Dressing of bi-chloride of mercury 1-5,000 replaced the weaker solution.

May 11th. In addition to this dressing hepar sulph. 2x every four hours, was prescribed. The patient had great pain in foot, headache, pain in stomach, felt sick all over. In order to avoid repeating, I wish to say that during this three months he had very little sleep, would only doze occasionally, and often cried out with the pain.

May 13th. Nux vomica, five drops of the tincture every four hours, was prescribed. The wet dressing of bi-chloride of mercury was used continually. The nux. vom. did not help matters, and in twenty-four hours hepar sulph. 2x every four hours, was resumed.

May 22d. External dressing changed to creolin and glycerin 1-20.

May 23d. A prescription, which I had not heard of until last night, was made by Dr. Charles T. David, of the house staff. This was Dr. David's first time to treat the case. He gave arnica 30th every four hours internally, and arnica 1-30 externally. The man

slept well that night, and had *very* much less pain. This remedy was stopped next day (not by Dr. David), and creolin in glycerin was again ordered. That night the patient did not sleep at all, and in addition to the usual severe pain in foot, developed a bad headache, toothache and pain in abdomen. Temperature 100.6.

May 25th. Dressing of bi-chloride of mercury 1-2000. Two days later silica 30th, one dose daily for four days, was prescribed. The wound was discharging pus, and sloughing.

June 2d. Cleansed with peroxide of hydrogen and dressed with bi-chloride of mercury 1-2000. Hepar sulph. 2x every four hours, was given internally. The discharge of pus and sloughing remained the same.

June 6th. Aluminum acetate, saturated solution, in daily alternation with ichthyol ointment (ichthyol, balsam of Peru, boracic acid and vascelin) was prescribed as a dressing and continued for about two weeks. At the end of this time the discharge of pus had stopped, but the pain and sloughing were just as bad. The ulcers were covered with a gray, unhealthy membrane.

The following dressings were then used: Balsam of Peru, which resulted in a slight relief of the pain (the only relief thus far, excepting when arnica was prescribed in the 30th potency); arnica locally, 1-40, no result; aristol powder, resulting in formation of a scab of unhealthy cells, otherwise no change; calendula, 1-30 locally, and in the 30th potency, internally; no result excepting a slight relief of pain.

July 8th. Re-amputation was decided upon as the only possible procedure, because of the short flaps and dead bone. Washed with bi-chloride of mercury 1-5000, and dressed with calendula 1-10. This was continued until the 17th with no improvement, when he was prepared for operation. The anæsthetic (hyoscin, morphine and castin) failed to work, however, and it was put off until the next day. At six P. M. I was asked to prescribe for the case. Characteristic indications were as follows: Sore, bruised pain in the foot, would draw away if anybody approached the bed, he was so fearful of being hurt; extreme suffering when foot was dressed; would pull it away from the slightest touch. Arnica 30th every two hours was prescribed, and arnica 1-100 applied locally. He slept all that night, and complained of no pain the next day. The dressing was not removed for four days, but was kept wet with the arnica solution. At the end of this time healthy granulations had formed, and no pain or sensitiveness was experienced.

July 25th. Almost well, could walk about ward without the slightest discomfort. He slept so much that sometimes he could not be awakened for meals. Arnica cerate was substituted for the solution.

July 29th. Ulcers on first two toes *completely* healed.

August 1st. Arnica discontinued.

August 5th. Last ulcer *entirely* healed.

During this treatment arnica 30th was discontinued for two days, but a little pain returned and it was resumed.

In reviewing this case we see that bi-chloride of mercury, creolin, balsam of Peru, ichthyol ointment (ichthyol, boracic acid, balsam of peru and vascelin), aristol, calendula, aluminium acetate and arnica locally; hepar sulph., nux vom., silica and calendula internally, had failed to help the case in over three months. Failed because they were not according to nature's law of cure, or because they were not indicated by the symptoms.. Arnica 30th administered according to homeopathic indications, along with its external application, as the trouble resulted from external violence, brought prompt results ending in a *complete* cure in nineteen days.

The modern tendency to branch out into special fields should not be encouraged at the expense of our materia medica, for we must remember that the body is a unit, and we as physicians treat sick people, not sick toes, as in this case; for the toes are part of the man and cannot be treated separately, unless they can be taken from him and made to live an independent existence. I have not as yet seen any toes walking about without the man, however.

After considerable experience with ulcers and pus cases, obtained largely at the Metropolitan Hospital a few years ago, am convinced of the futility of antiseptics and of the great efficiency of the indicated homeopathic remedy.

DISCUSSION.

WILLIAM M. BUTLER: I do not wish to discuss this case, but I wish to put in a little testimony on another line. For many years I have had my sheet anchor out for dissolving blood clots. In cases of embolism or of cerebral hemorrhage it is the one remedy, in my experience, that will give relief. In the Cumberland Street Hospital the day after to-morrow, you can see several cases that have received arnica 30, where there was partial hemiplegia, and other cases where there was complete hemiplegia. I have seen cases, a great many of them, where there was complete hemiplegia, and in which the patients received nothing but arnica 30, and afterward, in the last stages, perhaps, some electricity, and which have been completely restored both as to motion and sensation. I always expect to get help from arnica 30 where there is clear evidence of a blood clot.

MELILOTUS IN CONGESTIVE HEADACHES.

J. IVIMEY DOWLING, M. D.,
ALBANY, N. Y.

I wish to call attention to melilotus in its use for the relief of headaches of the congestive type, and to two cases which particularly illustrate its efficacy in eye cases.

One was in the case of a hemorrhage which occurred at the time of the acme of the marital relations, with severe headache, which continued for some days. Melilotus tincture relieved that absolutely and there has been no recurrence.

Another case in a younger man, newly married, who at the time of the marital embrace suddenly became blind. He consulted me. I found there had been a profuse hemorrhage in the retina, which was dissolved. He also complained of this congestive type of headache. The whole thing was relieved by the use of melilotus tincture. These cases showed objectively intense engorgement of the nasal tissues. The erectile tissues of the turbinated bodies were so engorged that the whole upper portion of the nose was occluded in both cases. All this subsided, and without local applications they obtained free breathing space after that. They only had to take the remedy for two or three days, and they were all right. The hemorrhage in this second case was relieved very quickly, more quickly than I have seen in any other case.

I remember another case which occurred a few months ago from the same cause, this congestive type of headache. He had been married a short time. He was a physician and had taken remedies and had remedies applied and given, but they did not relieve. Melilotus tincture relieved it within an hour's time, a headache which had continued for several days.

I speak of this because it is a remedy that is excellent in congestive headaches, and is often considered along with belladonna; but personally I have not found that throbbing which you do find in belladonna, but I have found objectively intense engorgement of all the nasal tissues, and the erectile tissues especially, so that I consider it a very valuable remedy in headaches due to sexual irritation.

ARSENIC VERSUS CARBOLIC AND THE CRESOLS IN SURGERY.

W. H. FREEMAN, M. D.,
BROOKLYN, N. Y.

Arsenic is frequently indicated in adynamic surgical conditions, and in gangrenous, suppurating wounds of patients with low reactive power; especially after the local use of carbolic acid or creolin in such cases.

These patients occasionally become too lethargic to manifest the typical arsenic symptoms, though the history will usually show them to have been present earlier. Reaction is often entirely lacking, and the germs have their own way within the tissues, in spite of anything which surgery can do on the surface.

Antiseptics may limit the amount of pus, but complicate the condition further through their absorption into tissues already devitalized by constitutional disease.

These patients are always extremely sensitive to carbolic acid, and as it is in these particular cases that conditions often arise which tempt the surgeons to use carbolic or some of its analogies locally, for the bad effects of which arsenic is also the best antidote. This remedy, under such circumstances, will invariably promote healthy reaction and usually bring about a cure even in the most desperate and otherwise hopeless cases, provided it be given in dosage and potency suitable to the condition.

About eighteen months ago a patient consulted me regarding a leg ulcer of fourteen years' duration, which had been unsuccessfully treated by many physicians. She had been using weak carbolic dressings for years to dull the pain and kill the odor. She objected to my removal of the dressings, because the odor and appearance had always made the previous doctors sick, one of whom had vomited. I cleansed and dressed it aseptically, however, but found it the most disagreeable task of my career, and it was almost impossible to get rid of the stench in my office afterward.

Arsenic 1 m., 1 dose, was followed by rapid and marked improvement; the odor disappeared, inflammation subsided, healthy granulations began to appear; suppuration greatly decreased; the awful restlessness and burning pains ceased almost entirely, and she was able to sleep comfortably for the first time in many years.

Last April I was invited to prescribe for a seemingly hopeless case in one of the hospitals. The man had been bedridden for three months and had had repeated operations for a gangrenous, suppurating condition of right hand and arm, following an injury to the thumb. Though the thumb had been amputated and the arm

well opened up and thoroughly drained, the condition had been steadily growing worse, in spite of careful surgical attention. Suppuration extended up the muscle and tendon sheaths to the axilla, the wounds were gangrenous and granulations absent. The arm was being dressed four times a day and wet dressings at five per cent. creolin were being used in the endeavor to keep the infection under control.

The patient was soporous and unable to give any symptoms, so there was nothing to prescribe on but the local pathology and the probability of creolin poisoning.

From previous clinical experience, I was led to prescribe arsenic 1 m. 1 dose.

Within twenty-four hours a most remarkable improvement in the mental, as well as the general and local condition, was manifested, and the patient left the hospital cured in about three weeks (except for the anchylosis), and he has been enjoying excellent health ever since, according to recent reports.

In this case the creolin dressings were continued by the surgeon in charge for about a week, or until he felt it safe to remove them, though I had protested that they were unnecessary and detrimental after the patient came under the influence of arsenic. They had been inefficient for several months, and only after the arsenic did the patient begin to improve. Arsenic in this case was given every four or five days, and only repeated on evidence of ceasing improvement, or at the end of the positive phase, according to apsonic terminology.

Last month another surgical patient, who had been in the hospital about four months for a gangrene of the left leg, that had been amputated at the knee and later at the middle of the thigh, was turned over to me only after the condition had become absolutely hopeless.

The stump was gangrenous and suppurating profusely. Diarrhœa and evidence of abdominal phlebitis were present. The stump had been painted with Tr. Benzoin Comp., containing a small percentage of carbolic, and dressed with five per cent. creolin wet gauze, frequently changed. Arsenic 2x had been given in frequent doses for several days, but without any apparent effect. The patient was anæmic and exhausted, complained of the intense burning pain, and showed the mental and physical anguish and restlessness so typical of arsenic—all of which had been present from the first.

A course of arsenic in proper potency in the beginning, or even at a later stage, following the first operation, when there still must have been considerable vitality existing, would have cured the patient and saved her this long continued misery, and would have been a triumph for the surgeon.

The stump was now cleansed with salt solution and dressed aseptically, though same had been tried on several occasions with bad results. Arsenic 1 m., 1 dose, was given internally.

The pain ceased almost entirely within a day or two, the suppuration and the diarrhœa were greatly lessened, a poor lot of granulations appeared and the patient felt quite comfortable. Dr. Stearns, who succeeded me, continued the medicine in single doses as required to control the symptoms and ease the patient, until her death, a week or ten days ago.

The last two cases are a matter of record, and the facts can be easily verified, and are no more remarkable than hundreds of other cases in the medical service of the hospital just referred to.

Most surgical cases are easy to prescribe for, and the advantages arising from careful prescribing more than pays for the time spent in looking up the symptoms in the repertory when necessary. Cases too difficult or complex for the surgeon should call for consultation with some good prescriber. It is customary for the physician to call in the surgeon, though but rarely does he reciprocate. Seemingly, he would rather have his cases die first, as is too frequently and needlessly the case.

Surgery and Homeopathy are sister arts. Each needs the other, and instead of each ridiculing the errors of the other, it would be better for both and a boon to humanity if they would get together oftener with the object of supply their mutual deficiencies. It is only through such co-operation that the best results can be obtained, and fatalities avoided in a great many cases.

In closing, I wish to insist that it is impossible for anyone to get the best out of Homeopathy unless willing to abjure prejudice and use that potency which best corresponds in its ionic vibrations to the morbidity of the patient.

ELEVEN SUCCESSIVE CASES OF DIPHTHERIA.

JOSEPH HASBROUCK, M. D.,
DOBBS FERRY, N. Y.

No. 1. November 9. J. S., ill two days of sore throat. Inspection showed both tonsils covered with gray membrane and the cervical glands enlarged. Prescribed kali mur. 6x, 5 grs. in 10 oz. water, and a teaspoonful given once in two hours.

November 10. Membrane extended to the palate. Same medicine and dioxygen, two teaspoonfuls in half a tumblerful of water, teaspoonful doses, in alternation with kalilum hourly.

November 11. Membrane extended to the nose, and breath very offensive. Merc. cyanide 30th once in two hours.

November 12. Much better and medicine continued until 18th, when the membrane came away and the nasal discharge was watery and exconating. Arum tryphillum 6th, once in two hours. Novem-

ber 25. Urine sooty and patient had difficulty in swallowing liquids, which pumped through the nose. Causticum 6th cured in three or four days.

No. 2 November 22. The mother of No. 1 took to her bed with left tonsil covered with membrane, and deglutition very difficult and painful. Lachesis 6th cured in three days without change of remedy. I gave the family of ten dyoxygen from the second day, and there were no more cases, though isolation was not perfect.

No. 3. January 10. A. E., aged 12, much fever, both tonsils covered with gray membrane but throat not painful. Kali mur. 6th once in two hours.

January 12. Better in every respect, and dismissed the patient cured on the 15th.

No. 4. January 13. B. C., aged 9, had been ill two days with sore throat. The pharynx was covered with tough gray membrane. Kali mur. 6th hourly for a few hours, and then once in two hours.

January 14. Improved. Remedy continued and the patient cured on the 18th.

As there were nine children in the house of four rooms, and no chance for isolation, I gave the family kali mur. in hope of preventing more cases, but without any effect, excepting to cure a child of enuresis, from which she had suffered for seven years.

No. 5. January 21. A sister, aged 9, well-marked case with much glandular swelling. Kali mur. once in two hours. 22d. No better, much fector oris and nasal obstruction. Merc. cyanide 30th once in two hours, and continued the remedy until 30th, when the patient was cured.

No. 6. February 25. Agnes, aged 5, had a number of white spots on her tonsils, high fever, much aching all over and breath offensive. Phytolacca once in two hours.

February 26. Better. Phytolacca to be taken at long intervals.

March 3. Vomiting green liquid, and could not retain food or drink. Natrum sulphur.

March 4. Better, but vomited several times a day, and was greatly emaciated. Nat. sulphur.

March 10. Very cross and peevish, and constantly picking nose.

March 11. Better, and continued about the same until the 18th, when she was exhausted and refused food. Her condition was due to diphtheria, which had not developed in the usual form. Diphtherin lm (Swan) once a day for three days.

March 21. Bright and playful. Appetite and digestion good. No more medicine given until April 24th, when I found she could not control her legs. Correlation of the muscles impossible. Helloderma horridus, 200 once a day for three days, and in ten days she ran across the yard to show how well she could do it.

No. 7. March 3. Margaret has been ill of grip for two days. Both tonsils covered with membrane, severe aching throughout the body, high fever, yet chilly, great feotor oris. Baptisia 3d hourly.

March 4. Better. Continued medicine, less frequently.

March 6. Membrane nearly gone, but has œdema of the palate and stinging pains in the throat. Apis, once in two hours.

March 7. Better. Dismissed the patient, and well on the 10th.

No. 8. Kate, aged 17. Both tonsils well covered and nose stopped up; feotor oris. Merc. cyanide 30 once in two hours. Steady improvement and no change in medicine. Dismissed well in eight days.

No. 9. March 12. Isabel, aged 11. Left tonsil covered, deglutition difficult and painful. Lachesis 6th once in two hours.

March 13. No worse, but glands more swollen externally. Lachesis.

March 15th. Throat clear of membrane, but left side of neck so swollen as to produce wry neck. Calcium iod., half grain in ten teaspoonfuls of water. A spoonful every two hours.

March 16. Marked improvement. Continued medicine three times a day. Cured on the 19th.

No. 10. January 15. Girl aged 10. Taken ill in school in the afternoon. High fever, intense aching kali mur., which was not a good prescription. It should have been phytolacca.

January 16. Fever less, but the pharynx was covered with membrane, the nose was involved, and the patient had to sit up to breathe. Lycopodium 30. Evening, better in every respect. Parents wished antitoxine, so I advised calling another doctor, who believed in it, and gave up the case. The serum was injected the next morning, and repeated a few times, and the child died in less than a week of the chestnut "heart failure."

Cases 4 to 9 were in one family with four rooms, and only the mother to do all the housework and nursing, so isolation was impossible. The rooms were scrupulously clean, however. No local treatment was given, except a gargle of normal salt solution.

There was just time to have the wall paper removed and the walls whitewashed, when the mother gave birth to another boy, without any septic complication.

I have decided to bring this paper to an end in order not to trespass on time which will undoubtedly be more profitably taken up, but will remark in conclusion, that diphtheria cannot be homeopathically treated, successfully, except by one remedy at a time.

There were several deaths during the epidemic, but none of the victims died without the benefit of antitoxin. Do not understand me to say that all who got antitoxine died; and I believe that the antitoxine treatment is better than heroic doses of crude drugs or combination tablets.

DISCUSSION.

AUGUSTUS VON DER LUHE: There is no doubt in my mind that cyanide, in its action upon diphtheria, is far preferable to the action of antitoxin. I believe there are true cases of diphtheria that are

bound to be cured where the remedy is indicated; and those cases that are on the left side—the Doctor spoke of causticum, of the throwing back of liquids through the nose—I have never had any experience with that, but I have always found that lachesis was a very prompt remedy and gave quick relief.

W. H. FREEMAN: The Doctor spoke of diphtherinum in one case. I have never prescribed diphtherinum in diphtheria, but I make it an invariable rule to give diphtherinum as a prophylactic to other members of the family whenever I get a case of diphtheria. I have been giving diphtherinum as a prophylactic now for two or three years, and have not as yet had a second case in a family that had taken that remedy. Dr. H. C. Allen, of Chicago, to whom I spoke about this, said he had been using it with that experience for twenty-five years. Diphtherinum, Skinner's potency, 1 m. is what I give, two or three doses, twelve hours apart. In the part of the city where I practice there are a great many poor people, and they sometimes have very large families living in a few rooms, sleeping five or six in a bed sometimes, a layer at the bottom and a layer at the top, and every chance in the world for all to become infected; and I think under those circumstances, when you can say you have never had a second case under the use of diphtherinum, it means something.

PITYRIASIS RUBRA—A CASE.

WILLIAM L. LOVE, M. D.,
BROOKLYN, N. Y.

Pityriasis rubra is a rare type of skin disease in which there is extreme congestion with consequent hyperemia, as the result of which the skin scales off in large flakey pieces.

It involves a varied degree of surface, which may be continuous or in patches which tend to coalesce. There may be intolerable burning and itching, although in mild cases these unpleasant symptoms may not be marked.

At the onset, the patient usually experiences a certain amount of pruritus, and generally complains of a sensation of chilliness. This condition may persist without any notable change for a year or more. After awhile the skin begins to appear tightly drawn, and fissures and ulceration occur. The facial expression becomes greatly altered from the lessened mobility of the lips, and the hair and fingers become friable, lose their lustre and are often lost. In all the cases I have seen—numbering a dozen, probably, in the last six years—most of them at the Skin and Cancer Hospital, N. Y., there has been the characteristic ectropion with conjunctival engorgement noticed

in the present case, although the eversion of the lids is not now nearly so marked as it was when I first took the case under my professional care. I emphasize this appearance of the eyes because, in my experience with these cases, I have come to regard it as pathognomonic as is the dry, brown, cracked tongue with the characteristic facial expression indicative of typhoid fever.

In some instances the eruption has been localized, as in the hands and feet. In others it has occupied large areas and has tended to recur again and again.

Often, in the incipiency, we find reddened patches covered with a fine desquamation appearing in the axillary, inguinal and popliteal regions. Later, there is infiltration and thickening, and then the shedding of fine, branny scales, giving to the disease its name—exfoliating dermatitis.

This disease is not contagious, although its particular habitat seems to be the South American countries and Panama. It resembles chronic erythematous or squamous eczema, in which there is considerable thickening of the skin, pruritus, and often a moist surface with the thick, sticky eczematous discharge.

Psoriasis, too, might be confounded, but its resemblance is less marked, for it rarely covers every inch of skin, but leaves small areas unaffected. The scales, too, in psoriasis are thicker and lack the branny character of dermatitis exfoliativa.

Fox says: "The general health fails, and without the best of care and nursing, the patient falls into a pitiable condition. At best, the prognosis is extremely grave." Bulkeley says that these severe cases are generally fatal.

Case —. Mr. L., aged 56 years, of Brooklyn, referred to me by Dr. Fiske. He had been under treatment at the New York Skin and Cancer Hospital for two years. Had enjoyed baths, emollients, alkaline and tonic remedies, constant envelopment in oil, together with internal remedies galore, including large doses of Fowler's solution of arsenic.

He had started to scale on the head about three years ago, noticing a spot about the size of a silver quarter covered with dandruff, which spread and was very persistent. After a month, red pimples came out on the body like prickly heat, and afterwards dry powdered scales were all over the body.

He was greatly discouraged when I saw him, for after two years' persistent and daily treatment at the Skin and Cancer Hospital, he was given up as a hopeless case. Professor Bulkeley said he was incurable, and he grasped at Homeopathy as a drowning man clutches at a straw.

After carefully studying his case, my first prescription was pulsatilla. This was followed by psorinum, sulphur, silicea and resorcin in the order named. (The resorcin I had especially prepared by Boericke & Tafel). After two months' treatment, during which time ointments that had been absolutely essential to his comfort and relief from intolerable itching, had been *absolutely eliminated*, he

reported that he was sleeping better than he had in two years, and had not now as much itching, even without the use of ointments, as he had before with them. For the first two or three days after we started treatment, the pruritus was almost intolerable, and bicarbonate of soda baths were permitted, and afforded some very slight relief. He also reported that the congestion was less, the color better and the skin more pliable and natural. Also the *lymphatic glands of the groin, which were as large as hen's eggs, and never diminished in size during his two years' residence in the hospital, have entirely disappeared.*

My case book shows after this a slight setback. Considerable pain and swelling of lower and upper lips, which blistered and burned intensely, were puffy and bloated with stinging pains. This condition yielded very nicely to apis, which was given in the 3d dilution—two drams before each meal and at night. For the intense itching, dolichos pruriens worked like magic, also gave him several applications of the Piffard hyperstatic current with the glass electrode, the carbon point proving entirely too severe, and the aluminum electrode even harsh, so extremely sensitive was his skin.

By the end of four months he reported that he could see the blue veins in his arms for the first time in two years—the body being several shades lighter, the pain and itching greatly relieved. The chest is much better, although the back is covered by scales which, however, are much finer than formerly and more like powder. Feet and legs entirely cleared. Disease seems to spend all its force now in his face and neck.

He was now a typical arsenicum case, and I gave him that remedy with confidence in the homeopathicity of its action. And I was not disappointed. At first I gave it low, but as it seemed so absolutely a similimum to the case, in the line of experiment—*pro causa scientæ*—I went higher, and absolutely, he seemed to respond more quickly to the higher than the lower potencies.

I cannot understand why 1 part of copper to 1,000,000,000 of water means death to algæ. The human mind cannot realize how the infinitesimal can accomplish such an effect, but facts are facts, and I firmly believe that in the treatment of chronic cases, particularly of skin cases, the nearer we get to the remedy absolutely homeopathic, the nearer we get to a similimum between the drug disease and the lesion to be treated, the safer it is to ascend in our potencies, *as long as we notice improvement continuing;* for there is a hidden something about drug action which, when elucidated, will be as valuable to scientific medicine as the pathological researches of Virchow, the laws of similars of Hahnemann, or the antiseptic discoveries of Lister. I cited this case to our Kings County Homeopathic Society some months ago, before the Opsonic theory of Wright, with its emphasis on the hidden power of drug action, had received the attention from the profession at large that it is now receiving.

My patient, Mr. L., is still taking the arsenicum night and morn-

ing. I do not call him cured—he was pronounced incurable by no less eminent a dermatologist than L. Duncan Bulkeley. But Mr. L. himself believes that Homeopathy affords the only scientific method of prescribing. I have seen at the New York Skin and Cancer Hospital hundreds of dermatological cases of all sorts and descriptions. I think it is one of the worthiest of the charities of this great city, affording relief, cure, health and happiness to countless thousands. Dr. Bulkeley and his staff of learned and experienced assistants give of their valuable time, without money and without price. Some of the results that I have witnessed have been most brilliant. But I firmly believe that there come to them many cases that they will never be able to help until they learn the value of internal medication, as applied according to the law of Hahnemann.

DISCUSSION.

B. L. B. BAYLIES: In cases of chronic skin disease which I have treated, cutaneous, squamous troubles, I have found the very high potencies, not frequently repeated, most beneficial. I have frequently observed aggravations from doses when too often repeated.

LACHESIS.

NATHANIEL ROBINSON, M. D.,
BROOKLYN, N. Y.

Mrs. M., a long sufferer from obesity and sluggishness of all the abdominal organs, had been treated for years for a chronically congested liver. When she came under my care, after several years of drugging by calomel, nux vomica, etc., I found a most obstinate case to deal with. She had tenderness over the liver on pressure, excessive jaundice, with urine almost black from the presence of bile, and many symptoms of intestinal indigestion.

I prescribed for some time without results. One day she mentioned that she was covered with black and blue spots. On examination I found as many as one hundred hemorrhagic spots all over the body. These spots she said she had had at times before. They were not present at the time I first examined her. With this added symptoms I gave lachesis 12x. She began to improve, and the improvement was so rapid and marked that there can be no doubt of the remedy.

The obesity disappeared in great measure, and with it many of the obscure troublesome symptoms which had been prescribed for in vain for years. Once since she had a slight relapse, and a few doses of lachesis gave prompt relief.

DISCUSSION.

AUGUSTUS VON DER LUHE: In all cases where you have those blue and dark spots, it probably is an indication of the remedy. Lachesis is bound to be the prominent remedy, prompt to bring the cure. If these spots had not existed, certainly lachesis would have failed to cure the case, and the Doctor certainly was very wise to take that as a picture or the map of his case, the points that guided him, as the compass would, to the treatment.

LACHESIS IN PURPURA HÆMORRHAGICA AND PELIOSIS RHEUMATICA.

WALTER B. WINCHELL, M. D.,
BROOKLYN, N. Y.

My case is somewhat similar to Dr. Robinson's. This was a young woman, married one year, pregnant the third month. She had been a patient of mine from childhood, but had married and moved out of town. She was reported to have been treated for a long time last autumn for malarial intermittent fever—what form of treatment I do not know. But at the time she came into the city she was suffering so intensely with the nausea of pregnancy that her mother had sent for her to come home, thinking that the change might do her good, and I was called. I found the uterus retroverted, and I introduced an Albert Smith pessary, which held the uterus up, and she got very prompt and permanent relief in that respect; but she still complained of being languid, absolutely no appetite, tired out all the time, and various remedies that I prescribed for her did her no good whatever. After a few days she appeared one morning in great alarm and called my attention to hemorrhages in the skin. I found, as usual in purpura hemorrhagica or purpura simplex, hundreds of minute vibices below the knees, and on the upper part of the leg, about the hip and thigh, very large, ecchymotic spots, some of them as large as the surface of my hand, though there were no hemorrhage from the mucous membrane at that time. I believed it to be only a case of purpura simplex, and not serious. However, the next day she appeared again with her handkerchief at her face, saturated with blood. On examination I found the nose was constantly oozing; on the roof of the mouth, on the soft palate, on the inside of the cheeks, there were almost a dozen bleeding points, some a quarter of an inch in diameter. I asked carefully if there had been any hemorrhage from the uterus, knowing from the history of those cases that that might be expected; but so far there had

not been. I prescribed at once lachesis, and asked her to report daily. The next day she came in and the first remark she made was that she had a feeling of well-being that she had not known for months. She said, "I feel better, I don't know whether I am any better." The hemorrhages were ceasing, there was not nearly the amount of oozing there was the day before. On the second day the hemorrhage had ceased entirely, and the ecchymosis disappeared the most rapidly of any that I have seen. She went through her pregnancy, and has had no recurrence of this trouble. No change in habit or diet was made, and after the appearance of the ecchymosis no drug was used except lachesis.

The second case was a case of Schönlein's Disease—Peliosis rheumatica, purpura rheumatica—several names, but the condition, of course, is the same. This was a gentleman I had attended for fully twenty years. I attended his father and his mother before him. He inherited from each of them a very strong tendency toward rheumatism. The father was, in fact, gouty, and his mother had rheumatism for years before she died. He had been in good health. I do not know that I ever was called to his house to see him before, although I attended other members of the family. I found him suffering apparently with rheumatic arthritis, joints swollen, painful, fever, sour sweats, everything to lead me to think I had an ordinary case of rheumatic fever. I prescribed for him, regulated his diet as well as I could, but absolutely without any result whatever. Where I had been in the habit of seeing certain results from drugs in those cases, there was no result whatever, until after a week or ten days he called my attention to some blue spots on his body that had just appeared. I found on him a large number of ecchymotic spots, not the small vibices that we get in purpura hemorrhagica, but from the size of the thumb nail up to half a dollar or a silver dollar, most prominent around the joints that were affected, but also on other parts of the body. This at once led me to think of a hemorrhagic case, and I gave him lachesis. The result in this case was that the joints affected were relieved very markedly and very quickly. The ecchymosis disappeared very slowly. It was weeks in disappearing, directly opposite to the case of purpura hemorrhagica. He was able to go to business in a very few days, but several weeks afterward he came to my office and showed me that the purpuric spots had not fully disappeared; so that the remedy, while it acted on the joints, where I did not expect it to, did not act as prominently on the ecchymosis. I believe the history of Schönlein's disease is that the eruptions appear mostly around the joints, but usually precede the pain. In this case the hemorrhage did not precede the pain in the joints.

DISCUSSION.

W. S. SEARLE: I have been in the habit of using crotalus in such cases. Can anyone tell me when to use crotalus and when to use lachesis in those cases?

G. W. MCDOWELL: I do not know that I can answer Dr. Searle's question. I did not mean to break into the symposium, but Dr. Searle's question recalled a case in which I prescribed lachesis first and crotalus afterward. It was a case of purpura hemorrhagic occurring in a young man 25 years of age, who had had an attack of what was diagnosed as malaria, in the country, and had been treated by large doses of quinine. After a week or more of that treatment, during which time he took some 30 or 40 grains of quinine a day, he began to bleed from the gums, and the doctor became frightened and advised him to go home—the best way of getting rid of him—giving a very unfavorable prognosis. I saw him, I think, on the second day of the bleeding, and he was then saturating handkerchiefs at the rate of one every fifteen or twenty minutes. At that time he had the purpuric spots well developed all over the body, and I prescribed lachesis. I saw him twenty-four hours afterward and found that he was passing bloody urine. Thinking I had not a remedy that was deep enough acting, I gave him crotalus, I think about the twelfth centesimal potency, although I have forgotten—it was a long time ago—and within twelve hours the bleeding had stopped from the gums, and in two or three days there was no sign of bleeding anywhere. I fail to recall just now as to the purpuric spots, whether they cleared up, but he was entirely well inside of a week after the use of the crotalus. Whether he would have recovered under lachesis I do not know, but he certainly did recover after the crotalus was given.

WM. S. SEARLE: Unless I am mistaken, it is a condition, in all these cases of purpura, that there is a lack of fibrin in the blood, and I believe that that is caused by all kinds of poisoning, and therefore my own opinion is that I have never been able to make any distinction in those cases; and both crotalus and lachesis have worked very finely with me. But I am inclined to think that certain poisons produce that effect, destroy the fibrin of the blood, prevent its coagulability and consequently increase hemorrhage.

GUY B. STEARNS: I think I can say a word on the subject of crotalus and lachesis in cases which I have had, which are few in the hospital, where crotalus has benefited and where lachesis had been given. The lachesis symptoms of aggravation from pressure, that is, the intolerance of pressure about the neck, and the morning aggravation, were absent, while the hemorrhage was perhaps rather more profuse. I think that there is that difference between the action of crotalus and of lachesis.

W. B. WINCHELL: In the case Dr. McDowell reported as a case having taken a very large amount of quinine for a number of days, I am reminded that when I was looking up this subject I found, in

Osler, I think, several of the text books which I looked up very thoroughly, that one of the principal causes given for the occurrence of purpura hemorrhagic is the giving of large doses of quinine to people who do not take well to that drug.

AUG. VON DER LUHE: I would like to mention another fact, in regard to lachesis in vertigo. We very often come across cases of women in the change of life who are troubled with hot flushes and rushing of blood to the face and body, with perspiration, and they become very dizzy, so that they almost fall down; in going upon the street the dizziness becomes so great that they almost fall. I have never found in those cases, where there has been the characteristic of a change of life in combination with this form of vertigo, but that lachesis would give prompt relief and would effect a cure.

STAPHYSAGRIA IN CHALAZION.

J. B. GARRISON, M. D.,
NEW YORK CITY.

I am not an oculist, and do not try to steal cases from them, but I have to report a case that I was unable to steer their way, and had to cure her myself.

Miss M., aet. 59, had been a patient occasionally, and on April 12, 1907, she called to ask me what she could do to have "this lump on my eyelid," as she called it, removed. I told her that the oculists sometimes used the knife to get rid of it. She informed me that she knew that, and that she did not intend to have any knife near her eye yet, and had, for that reason, consulted me to see if something local could not be suggested. I told her that homeopathic remedies would bear trying, and had many times been successful, and that with her permission I would prescribe for her. Questioning her, I found a sort of undefined uneasiness of the stomach, which she said was "billiousness." She said she was disposed to be tearful, which was not natural to her. Complained of a pressure in the nape of her neck, on the right side and running up into the occiput, aggravated by movement or by going to the fire. Perspired very profusely, especially upon the face and arms. Has a weakness of the legs sometimes, making it hard to get around.

I confess that the clinical value of the drug for chalazion was in my mind at the time, but I saw that many of the symptoms she gave were included in the pathogenesis of staphysagria, so I gave her a few powders of that drug and directed her to dissolve them in water and take a teaspoonful every three hours, during the daytime. I did not see the patient again for a long time, but heard from her frequently through a relative, who came to the office every week,

and for several weeks there was no progress reported. The patient, being well supplied with blank tablets, was encouraged to keep on with the medicine, and did so. The patient herself did not report until August 2d, when she came in for something else. The chalazion was entirely gone, and had been, she said, since sometime in June.

I have in mind another patient, a girl of about 22, who is very nervous, has an irascible temper, and who is liable to have stomach trouble, with belching of much gas and accompanied with a great deal of vertigo. She is extremely peevish and irritable. She had had a chalazion removed by a surgeon before I ever saw her, and it reappeared. I gave her staphysagria, which caused it to nearly disappear. It has commenced to enlarge a number of times in the past five years, but a few doses of the remedy always check it at once, and she now always has a few powders on hand to be prepared.

DISCUSSION.

RUDOLPH F. RABE: I would like to say one word in reference to staphysagria, and that is that sometimes it will fail; and in those cases, thuja follows very nicely, and frequently completes the cure and does the work that staphysagria has failed to do.

A LYCOPODIUM CASE.

R. C. GRANT, M. D.,
ROCHESTER, N. Y.

George W. R., aet. 53, farmer. Has lost ten pounds in past three years. Very depressed; thinks he cannot live; wants to be alone; is better in hot weather. Sour, distressed feeling in stomach, worse from 4 P. M. until he eats supper. Gas in stomach which he cannot raise. Burning, raw, sore feeling in stomach. Gets hungry, but is quickly satisfied. Heart normal; urine normal. Slight dullness in upper right lung. No cough. Chews and smokes tobacco, drinks but little.

March 5, 1907. I gave lycopodium in cm. potency, and placebo. Did not change diet or habits in any way, although the patient had been growing gradually worse for three years, and had been to many physicians until, as he said, he believed himself incurable. I never had to repeat the prescription. The improvement was immediate and steady until, at the present time, not *one* of the original symptoms (including the dullness in lung) remains.

KALI BROMIDE IN A CASE OF CLIMACTERIC INSANITY.

GUY B. STEARNS, M. D.,
NEW YORK.

Eighteen months ago I was consulted by Dr. A. Lenora White about a case of insanity. The doctor had been called to make out a commitment certificate for a woman who lived near her. The patient had refused to see any physician, and strategy had to be resorted to in order that Dr. White could see her. The Doctor was introduced as a business woman, and after gaining her confidence, obtained the following history: She was about fifty years old, with fair complexion, dark hair, and blue eyes, short and fleshy and of Irish descent. She had passed the climateric about a year before, and with the exception of profuse menstruation, she had always had perfect health. She was a dressmaker by profession, and for a number of years had owned and carried on a large establishment.

The first evidence of her mental trouble occurred with the cessation of her menses. One day during her last menstrual period, she went shopping, when all at once, while in the store, she became possessed with the idea that the clerks were looking at her and making remarks, and the flow ceased at once, and never showed again. She left the store without finishing her errands, and went home much perturbed. From this time on she developed delusions of a persecutory nature. She would not go out of the house because everyone pointed her out as a bad woman.

Her next delusion was that a man on the next street, whose window was opposite hers, was making improper remarks and saying derogatory things about her. Next in order of her delusions she heard voices telling her that she was a wicked woman, and that the only thing for her to do was to kill herself, and kept insisting that she do it. Her persecutor now moved to an adjoining room and ran electric wires all over the house, and continually tormented her by sending shocks through her body. She complained of tingling in the limbs, which she said was due to the electricity.

At first she did not mind the voices, but after a time she thought perhaps she was wicked, and although she resisted their commands to kill herself, she was gradually breaking down, and felt that she would finally be obliged to make way with herself. She refused to permit a physician to be brought into the house, because these people controlled her, and told her it would be useless. She finally became suspicious of everyone, and during the last few months would not go to the table for her meals. She required constant watching, and finally the family decided that it was not safe to keep her at home, but were loath to send her to an asylum.

After seeing her, Dr. White asked them to wait a little while longer before committing her to an institution, and see what medicines would do. Before prescribing, the Doctor brought the foregoing history to me for consultation.

An analysis of the case from a diagnostic standpoint gave us little except descriptive terms, *i. e.*, "A Case of Delusional Insanity," occurring at the climateric, characterized by persecutory ideas and depression.

An analysis for the purpose of prescribing was difficult, since she absolutely refused to see a physician, and Dr. White was handicapped because she went under the guise of a family friend, who offered to get some medicines from a doctor she knew. The patient would become suspicious of the Doctor whenever she questioned her too closely, and would then refuse to talk or see her for a few days.

There were not enough general symptoms for repertorial work, and we had to select the remedy by exclusion. Her delusions were characterized by a depressed mental state which ruled out such remedies as hyos. stram. bella., etc. There was lacking the religious depression of veratrum, the weeping of puls., the loquacity of lach., the suicidal depression of aurum, the loss of memory of anacardium, and so forth.

There were not enough constitutional symptoms to warrant the giving of any of the prominent antipsories. By studying the list of drugs which produce delusions, and excluding those which seemed least likely, kali brom. was finally selected. She had the worry about her condition of the kalis, and the character of her delusions was similar to the brom. The previous profuse menstruation was covered by potash, so I felt the selection was justified. After much coaxing, the patient took the remedy. The 30th was given every two hours for a week, at the end of which time she was improved, and the remedy was discontinued. She continued to improve for nearly a month, when, because of a return of symptoms, a single dose was given. No more was necessary for several weeks thereafter. She became so conscious of her improvement that with her next exaccerbation she sent for Miss White (her friend, as she knew her), and asked her to please bring the doctor from whom she had been getting the medicine which she had taken, and I saw her for the first time. I found her systematic in her delusions, and she wished me especially to insist that the Board of Health compel the men in the next house to remove the electric wires. She was given a dose of kali brom. 200, and assured that the matter would be attended to at once. She has had only placebo since, and has had no more delusions. During the last nine months she carried on her dressmaking with a number of girls working for her. She has not, however, been out on the street since.

At an interview last week she remembered all her delusions and knew them to be such. She said she has had only one slight attack

of nervousness since. She carries in her mind the exact dates on which her delusions first came; the date of each of Dr. White's visits, and the date on which she first discovered that Dr. White was a physician, and in fact, the dates of all occurrences in her life during the last two years. She manifested an exaggerated idea of her importance as a case, but showed no evidence of irrationality.

A DIOSCOREA VILLOSA CASE.

RUDOLPH F. RABE, M. D.,
NEW YORK CITY.

Master K., age 5 years and nine months, ill for several days with an apparent inflammation in the ileo-cæcal region. He had suffered severe paroxysmal pain, coming and going suddenly, for which he had been given by his physicians, belladonna bryonia, and then the former remedy again, but without relief. In consultation the condition was found to be: Temperature 100.4; pulse 116; on examination and palpation, great tenderness over the ileo-cæcal region; rigidity of the right rectus abdominis muscle; on percussion, no dullness. There was no evidence of tumor. Pains paroxysmal, worse at night and coming and going suddenly. Four to five yellowish-brown, thin, slightly offensive-smelling stools a day. During the pains the boy would double up and then stretch himself out, pressing forward the abdomen. The latter motion appeared to relieve him more than the bending forward. At times during the paroxysms of pain, particularly when especially severe, the child's toes were drawn up. These symptoms and modalities were elicited after much guarded cross-examination of the parents. Taking, now, into consideration the symptoms mentioned, the totality of these pointed strongly to dioscorea, which was given in the 500th potency of Boericke & Tafel, three doses, at intervals of three hours. The last dose was taken at 5:15 P. M. At 9 P. M. the boy was still complaining of severe pain. Nothing but placebo was given. At midnight the boy fell asleep, and by morning was decidedly improved. The amelioration continued; stools became entirely normal on the second day, and within four days the boy was as well as ever, although weak. No further medicine was required or given.

NATRUM MURIATICUM IN VERNAL CONJUNCTIVITIS.

HERBERT DANA SCHENCK, B. S., M. D.,
BROOKLYN, N. Y.

Robert F., a healthy appearing youngster of four and one-half years, was first seen in July, 1906. He had had trouble with his eyes, which was diagnosed by one or two good oculists as vernal catarrh, which had, with the characteristics of this disease, returned with the approach of warm weather in the spring of 1906. He had been persistently treated from May, 1906, until I saw him, by one of the best Old School oculists in Manhattan, who had but slightly relieved any of the symptoms.

He suffered with that form of this disease which attacks principally the limbus of the cornea, the conjunctiva of the tarsus appearing normal. There was a row of gelatinous masses almost surrounding each cornea of a blueish-white color. There was slight inflammation of the conjunctiva near the cornea, but the peripheral portions of the bulbar conjunctiva, as well as the blepheral, appearing normal. There was slight photophobia, some irritability of the eyes, and enough itching with this irritability to cause the boy to be constantly digging his fists into them. The constant rubbing and the little watery discharge which was apparently slightly irritating, had caused some redness of the skin surrounding the eyes.

The youngster was apparently in the best of general condition, well nourished, and with no sign of enlarged glands anywhere. A boy larger than the average for his age, and withal, giving only the appearance of being a very sturdy, healthy youngster, which his father declared him to be.

Nat. mur. 6 was prescribed on pellets to be administered four times a day. He returned in a week with the eyes very much improved. Two-thirds of the growth on the limbus having disappeared, and the irritability of the eye almost gone.

A placebo was given, and he continued to improve, so that by the time he was seen again, ten days later for the last time, the eyes were perfectly free from irritability and remained so until June, 1907, when there was a return of the catarrh.

The mother had thought that the pellets left after the treatment of the previous summer would probably cure him, and had been giving the blank pellets for several weeks before she consulted me. The disease had presented much the same characteristics of the previous year, but much less severe. Nat. mur. 30 was prescribed to be taken three times a day, and the same prompt cure resulted, only the single prescription being made.

Although this is a very rare disease, it might be mentioned in passing that the prognosis given in most of the works upon ophthalmology is good as to ultimate recovery, but that the attacks may return year after year from four to twenty years, and most of them declare that up to the present time no plan of medical treatment, general or local, can be relied upon to cut it short.

CANTHARIS VESICATORIA IN NEPHRITIS, ENDOCARDITIS AND PERICARDITIS—A BRIEF STUDY OF THIS DRUG IN CARDIAC AND NEPHRITIC DISEASES.

WALLACE MCGEORGE, M. D.,
CAMDEN, NEW JERSEY.

At the request of the Chairman of the Bureau of Materia Medica, I have prepared this paper on this old-fashioned remedy. After you have heard it, and the discussions of those who have been appointed for that purpose, I should be glad to have the members amplify or verify what each has said of this royal remedy in the diseases named in the title.

"Cantharides, applied to the surface of the body soon excites tingling, smarting and a sensation of heat; the papillæ of the skin quickly become reddened and raised. Taken internally, it produces an unpleasant, burning taste; its active principle passes from the stomach and intestines into the blood."—Sydney Ringer.

Although occasionally used internally by the Old School, the principal use to which they apply the "Spanish Fly" is that of a corunter initacet, and in no disease does it act more promptly than in that of pericarditis or endocarditis, caused by metastasis from one of the joints of the body during an attack of inflammatory rheumatism. It does this work well because it is homeopathic to the case. Given internally in the 30th or the 200th potency, it will work as quickly, the effect will be more lasting, and the pain from the blister and consequent violent urinary symptoms resulting from its external application will be entirely obviated.

Babcock, in his admirable book on "Diseases of the Heart and Arterial System," in the section on Pericarditis with Effusion, writes: "We possess no means of either preventing adhesions or promoting the absorption of fibrinous deposits."

Had he ever tried cantharis or cactus in the high potencies, he would not have written so despondently.

Homeopathic physicians use cantharis externally in burns, inter-

nally in diphtheria, dysentery, nephritis, and pericarditis, but most of them look for the violent symptoms as seen after poisonous doses before administering it. In my experience, cantharis is oftener useful when there are no painful symptoms manifested in the case, as in those cases of dysentery where the passages are "white or pale reddish mucous stools, like scrapings of the intestines or like washings of meat," which we often see when there is very little pain and no urinary symptoms in the case at all.

To make this paper more interesting, and to show what many of our writers think of cantharis as a remedial agent, I have briefly collated some of their observations on this drug.

Mitchell, in his comprehensive work on "Diseases of the Kidneys," recommends cantharis in acute nephritis, when the micturition is frequent, with scalding urine and bronchial, laryngeal, or intestinal symptoms. He says, "It may possibly have a field of usefulness in diffuse nephritis, and in hematuria of renal calculus." "In renal colic in the high potencies when there is intense pain above the crest of ilium."

Jousset suggests cantharis in renal hemorrhage, in acute and suppurative nephritis. In pyelitis he says it is the principal remedy, not only in the acute stage, but in all stages of the disease where the urine becomes purulent and bloody, and voided with painful tenesmus. He relies on it in renal colic when there is cutting pain in left kidney extending along the ureter into the bladder. In the anuria of cholera, in cystitis, and in nocturnal enuresis, he gives it front rank. In salpingitis, he names it with aconite and colocynthis as the principal remedies. He also advises its use in skin troubles when they are accompanied with much burning. He also advocates its use in ascites, in acute pleurisy, and in advanced stages of pericarditis, when the fever is abated, to bring about resolution of the effusion.

Hering, in his Guiding Symptoms, gives "Loss of epithelium on lips, tongue and palate." My observations show that it has loss of epithelium on the intestines, kidneys and bladder as well, and that it promotes absorption of fluid from the pleura, pericardium, peritoneum and the feet. In fact, like sulphur, it is one of our best remedies for absorption of effusions, but it is not the remedy in all cases of this kind. The one that individualizes his cases will be the most successful. Jahr recommends it in hemorrhage from the nose, the intestinal canal, urinary and genital organs, and from the respiratory organs.

Nash advises cantharis for its effects upon the membranes to increase the secretions. This action is positive.

Guernsey, in his Keynotes, says: "It is a singular fact, though known to most practitioners, that if there be frequent micturition, attended with cutting, burning pains, or if not so frequent, and the cutting, burning pain attends the flow, cantharis is nearly always the remedy for whatever other suffering there may be, even in inflammation of the brain or lungs."

He recommends it in cases where "mucous collects in the posterior nares, whence it must be drawn down with much effort in the fauces and spit out." "One of the strongest characteristics of cantharis is, the patient is uneasy, restless, distressed, dissatisfied. The general pains, both external and internal, are stinging (fine stinging, not so severe as a bee sting), prickling, tearing, burning, biting, cutting, drawing, or gnawing; the bones, even, may and often do afford these distressing symptoms in a marked degree. Professor Lippe, in his lectures, told his students of the amorous frenzy, with shameless, unchaste gesticulations, which characterize the cantharis patient. He also told us that under cantharis, erysipelas always begun on the face. In case of profuse flowing two or three days after delivery, where the flow was accompanied with burning and smarting, it acts like a charm.

In Allen's Encyclopedia is the most voluminous description of this drug. It is surprising how many stitches run through this remedy like bryonia and kali carbonicum). It has stitches in the occiput, in the right temple, in side of head, in the chin, in the sternum, in the ribs, in lower ribs, and in the shoulder blade.

One of the provers reports: "A violent stitch, like pain in the left side of the chest in the region of the heart, or in the heart itself" (after five hours). "Stitch in the heart, followed by a crawling sensation." One prover, who had habitual palpitation of the heart, reports it entirely ceased while taking cantharis. Many of the provers record "anxiety about the heart." One prover writes: On the appearance of the urinary difficulties, the other difficulties cease." My observations show that one of the first effects of cantharis is an increased flow of urine, and as the urine increases in volume, the œdema and dyspnœa disappear.

In acute nephritis after scarlatina it is a valuable remedy, and if there is much blood in the urine so much surer is it the remedy. When the child is pale, anæmic has difficulty in breathing and seems unable to keep about, cantharis will put the patient on her feet again and enable you to restore her to health and vigor.

In the spring of 1885, a little girl about nine years old took cold while desquamating in scarlet fever, and soon had scanty urine, œdema of the feet and dyspnœa. In a day or two considerable blood was observed in her urine and the microscope revealed granular casts in large quantities. The flow of blood, was persistent and the child became anæmic. She had slight burning in voiding her urine, with frequent calls to urinate. I gave her cantharis 200 in water every hour. The burning was allayed after the second dose, and the blood in the urine was lessened in twelve hours. In two days it had entirely disappeared, and she made a speedy recovery. I kept her under observation for several months, and she had no return of any of these conditions.

In many cases of a similar character, but of less severity, cantharis has served me well, and in no case where I have prescribed

it has there been the distressing symptoms so often seen where cantharis is the remedy.

In endocarditis with mitral regurgitation, when the painful symptoms of the rheumatism have disappeared; when the appetite is poor or entirely absent, when there is short breathing, rapid pulse, and some œdema of the hands and feet, cantharis high will remove the œdema, increase the flow of urine, lessen the number of respirations, the patient will soon sleep better, eat more, and all the symptoms show improvement in from twelve to thirty-six hours; and in from five days to one week all the serious trouble will be gone except the valvular disease, and this you can relieve very much by aconite. spigelia, or spongia. If there is any soreness left around the heart after the endocardial or pericardial trouble has been removed, arnica, high, will drive the soreness away and reduce the heart muscle in a few days.

In pericarditis, when the patient hesitates about drawing a long breath, for fear of the pain brought on by the deep inspiration, my fellow student, Dr. P. W. Andrews, says he uses cantharis in the 6th potency every fifteen minutes until relieved, and relief comes in one hour.

Cantharis relieves the pain and removes the effusion. He also uses it in pericarditis when the face is swollen, with burning in the eyes.

Many more indications might be given, but time forbids. The following clinical case illustrates what cantharis will do in a troublesome cardiac condition.

May S., nine years old, had been under treatment in the West Jersey Homeopathic Hospital for six weeks suffering with articular rheumatism, with cardiac complications. She had had endocarditis, followed by mitral regurgitation before her admission.

Notwithstanding careful attention and good nursing, she did not improve, and once or twice had exacerbation of her endocardial trouble. I saw her once or twice with the attending physician, but there was no improvement.

On May 26th her temperature was 98.4, pulse 132, respiration 64, coughs continually, and although she was directed to lie down, "she *will* sit up," the record states. Her feet and ankles were swollen, the face was pallid, and the prognosis was not encouraging.

May 27th. Her face and feet were swollen and she could not lie down; her urine was examined by the resident physician with negative results, but no microscopical examination was made. Temperature 100.4, pulse 120, respiration 56. She had not slept much, and was very restless. Her countenance was anxious, distressed; face and hands were swollen; she had frequent calls to micturate, but very little urine was voided. On account of this last symptom, which was the latest to appear, I advised cantharis 30 in water, every hour, which was at once prepared and given to her.

May 30. Temperature 98.2, pulse 118, respiration 44. She had slept fairly well, had eaten a little, face was less swollen, and she had passed 12 ounces of urine. Same medicine.

May 31. Improvement in many ways; less œdema of feet; child wanted to eat, and asked for her doll.

June 1. Temperature 98, pulse 104, respiration 40; she had slept well; felt comfortable; 22 ounces of urine in 24 hours.

June 2. Temperature 98, pulse 100, respiration 28; had slept well, was comfortable; had passed 34 ounces of urine; swelling of hands and feet going down nicely. At 5 P. M. her temperature was 98, respiration 26, and the child asked to be dressed.

From that time until she went home on June 11th, her pulse and other symptoms continued to improve.

On June 10th, at 4 P. M. her temperature was 98, pulse 80, respiration 20. She had been having a large, formed stool every day; the urine became natural, the pallor left her cheeks, her feet were natural in size, and she went home cured of everything except the mitrot regurgitation. She received cantharis 30 for five days, after which she had sac. lac., so that cantharis could continue its action uninterruptedly until she was dismissed cured.

DISCUSSION.

J. T. W. KASTENDIECK: The advantage of a well-written paper on a subject in Materia Medica is, that our attention is frequently directed to some sphere of drug action which may have escaped our notice, or, in the more familiar usage, the individual presentation and verification often leads to our greater confidence in it and a better understanding of its correct and successful application.

There is, too, danger in such excellent description; viz., that we become enthusiastic, and use the remedy upon every occasion. The result that is sure to follow is disappointment, for it is as true to-day as in the time of Hahnemann, that there is no universal specific. In dismay and disgust the drug is discarded, and we lose a valuable means to combat the pathologic conditions to which it applies.

Cantharis naturally suggests itself in diseases of the urinary tract because it is there that we always find the first effects of its action when applied externally to the susceptible or in excess.

Its further application is suggested through the finer developments of drug proving or through clinical observation.

Burning and bloody urine are the characteristics to which our attention is most frequently called, but there are many drugs which present these same symptoms, notably: Capsicum, arsenicum, mercurius, especially the corrosive, terebinth and berberis vulgaris.

In the broader pathological distinctions capsicum would be indicated more frequently in conditions of bladder and urethra, than in the kidney inflammations; arsenicum in the deeper-seated affections of the kidney with marked blood changes; mercurius corros, while affecting the whole urinary tract the same as cantharis, has the most excessive development of tenesmus and those general characteristics of mercury that make its differentiation more easily possi-

ble. Terebinth has the frequent involvement of the organs of respiration, and is perhaps more nearly alike in its action to cantharis, but one does not look for the same intensity or acuteness in terebinth; while berberis suggests itself in mostly those effects resulting from the development of calculi or those systemic conditions which lead to their development.

In post-scarlatinal nephritis, in my own experience, arsenicum and terebinth have been as frequently indicated as cantharis. The supervention, however, of uræmic symptoms with developing coma would point to cantharis.

Apis mel. is also a remedy that has its application here, the greater the œdema the more likely is it to be useful.

The use of cantharis in nephritis seems to be, clinically, almost wholly in the more acute types, in spite of its beneficial effects in some cases of pyelitis.

Pericarditis, as well as endocarditis, are most frequently secondary, endocarditis almost always so.

Often they are secondary to those conditions of the kidney for the relief or cure of which cantharis is found to be the remedy. It is not astonishing, therefore, to find it useful in these secondary affections.

We find, too, in its affinity for serous, as well as mucous membranes, another reason for its application.

The "stitches" that run through the symptomatology of cantharis like the burning, are not peculiar to it.

The writer himself refers to bryonia and kali carb. "Stitches" are even more markedly characteristic of them than of cantharis. In the use of the cantharis, therefore, we must depend rather on the concomitant symptoms constituting a drug picture.

In these conditions if endo- and pericarditis, however, we must not overlook the action of pulsatilla, iodine, lachesis, spigelia, cactus, nitric acid.

Pulsatilla, cactus and nitric acid have "stitches," but each possesses its own peculiarity or distinction. Pulsatilla in the emotional sphere; cactus in its vice-like compression; nitric acid in its splinter-like pains.

Spigelia has its intense pains, greater in degree than any of the others; lachesis, its aggravation from sleep, and iodine, its oppression and "anxiety causing constant change of position."

But in none of those remedies do we get quite the same urinary conditions that we find in cantharis.

In pulsatilla we have the great remedy for metastasis, whether it be that from the tonsils to the generative tract, of measles to the brain, or of rheumatism to the heart. Its very name, "Wind Flower," is suggestive of shiftiness, its "disposition" of sunshine and shadow, of smiles and tears, indicates its changefulness. Yet we must not, because of this, conclude that its action is fleeting, for it is often in most serious and deep-seated pathological processes that we find it most useful.

The writer of the paper on Cantharis has called our attention to some of its spheres of action with which perhaps many of us were not familiar, but he has thereby proven that a drug cures when it is homeopathic to a case, no matter what the condition.

The nine-year-old girl was quickly relieved of her distressing symptoms and discharged cured because cantharis was her remedy. But we must not be led into the error of belief that cantharis will cure all other cases of the same disease.

Most writers prescribe cantharis in the low potencies and even in the tincture. The experience of Dr. McGeorge with the 30th and 200th attenuations however, shows what may be accomplished with them.

The minimum dose of cantharis, like the minimum dose of morphia, will vary according to the susceptibility of the patient.

We should not confuse doctrines with facts, nor deny the clinical experience of others because it does not coincide with our own.

DR. KASTENDIECK: I want to add that it seemed impossible, in a discussion of this kind, to go into differentiation of the symptoms, but upon the broader grounds we base our first ideas relative to the comparison of these remedies. The final details come when we get the cases and look them up with reference to the particular case for which we are prescribing. There are the general broader distinctions which I have tried to enumerate in the discussion.

We are criticised for not being scientific, for being visionary. Now, there are physiological grounds for the use of homeopathic remedies, as well as homeopathic grounds. The drug-proving shows that there are physical developments that are natural sequences, physiological developments that are natural sequences, one upon the other, and giving a good sound reason, aside from any pathic, upon which we may base our prescription.

RUDOLPH F. RABE: Dr. McGeorge speaks of the lack of distressing symptoms in most of these cases requiring cantharis. A word about that. I would like to verify that briefly in cases of erysipelas beginning on the nose, where the vesicles contain a very excoriating fluid, excoriating the skin over which the fluid flows; also in herpes zoster, where the fluid is hot and intensely excoriating, and in cases of dysentery, where there is a bloody shred-like discharge in the stools, tenesmus. In all three of these conditions we find vesical tenesmus, burning on micturition, but very slight; lack of distressing symptoms.

Sometimes the symptoms have to be produced by very careful questioning, the patient himself not placing any great importance or attention to them, saying merely that there is a slight burning—which verifies that statement.

MEDORRHINUM.

W. H. FREEMAN, M. D.,
BROOKLYN, N. Y.

The provings of this great remedy have never been as extensive or as thorough as the earlier provings of drugs made by Hahnemann and his disciples. Consequently, it is frequently necessary for the physician to draw upon his knowledge of the symptomatology of constitutional gonorrhœa in order to always know when the drug is indicated. A comprehensive knowledge of the pure symptomatology of sycosis is of great value, therefore, and its use perfectly legitimate when correctly utilized, since the symptoms of the disease and of its nosode are practically identical.

As the printed symptomatology of sycosis is very meagre, the physician must dig this information out of many hundred cases and family histories for himself; and exercise great care, while so doing, not to confound the sycotic with the non-sycotic complicating symptomatology usually present to a more or less extent in every case. Unfortunately, this seems to be too great a task for most physicians though it is an extremely interesting and profitable field for study, and one hitherto unexplored except by a few pioneers.

As has just been said, gonorrhœa of all stages is almost invariably associated with other complicating constitutional conditions, and it is this invariable tendency to arouse latent morbid conditions and to amalgamate with other forms of disease in the active stage, which renders the treatment of gonorrhœa, acute or chronic, so extremely difficult. In fact, cure is never accomplished except by prescribing for the different symptom groups separately and in an orderly manner, and by prescribing for the particular group most prominent at the time of each new prescription until finally nothing remains to treat, and the patient is well.

Even with a good knowledge of symptomatology, it is necessary to carefully differentiate between medorrhinum and the other antisycotic remedies, because the first is only indicated when the action of the disease is especially deep, long lasting, or profound, as is most often the case in malignant or congenital types.

It may be indicated at times in apparently insignificant ailments of otherwise robust individuals as, for instance, in a chronic, though mild catarrhal condition in a young man, which has resisted simple remedies well selected, and whose anamnesis shows that he slept on his knees as a baby, and that there is a history of catarrhal troubles and rheumatism, and possibly Bright's disease or cancer on the mother's side of the family. Here the history gives the cause of failure, and shows the deeply-seated character of the causal factor. The robust constitution of the patient prevents the disease from

developing in the usual manner, but it smoulders just the same, and unless he is cured with medorrhinum and its adjuncts, he is a subject for Bright's disease, cancer, or insanity later on in life, in spite of his apparent good health now.

The acute and subacute stages of gonorrhœa and the less profoundly manifested types of the chronic form, are covered by remedies which better correspond to the less deeply acting plane of the disease.

An important differentiating point between the nosode and other anti-sycotic drugs consists, therefore, in this difference in their planes of action, and it is important to remember this, because the nosode is liable to be extremely harmful when not similar to the case in this respect. If any doubt exists, always prescribe the other drug first.

Medorrhinum has certain positive characteristic symptoms, however, which seem to belong to its plane of action, and which are not covered by other remedies, and which when present should enable the careful physician to prescribe it safely and beneficially.

In certain cases the nosode may be the only drug necessary, though it has been my experience that all cases need other drugs sooner or later, for symptom groups which remain or develop after it has completed its curative action and for which it has no similitude.

In certain of its leading characteristics, medorrhinum closely resembles such drugs as arsenic, chamomilla, graphites, lycopodium, pulsatilla, phosphorus, secale, sulphur and thuja, and it is often the similimum when one of the afore-mentioned has been prescribed ineffectively, and it holds more or less of a complimentary relationship to them, especially so in the case of arsenic, chamomilla and pulsatilla.

The mental symptoms vary according to the individual. There may be the melancholic, tearful state of pulsatilla; the crankiness and irascibility of chamomilla; or the anxiety, restlessness, anguish or suicidal tendency of arsenic. They are always in a hurry. Time passes slowly. Is is such a hurry that he becomes tired out before he gets started or soon after. His intentions are good, but he never accomplishes half what he meant to do. Restlessness, can't sit still, and continually moving about (like arsenic); continually locking and unlocking his fingers. Restlessness in bed at night; child travels all over the bed in its sleep. Forgetfulness for names, for words, or for what has just been said. Forgets what he started out to say. Constantly losing thread of conversation. Makes mistakes in the use of words, in spelling, in calculating, and by transposing letters or figures when writing.

Mental dullness and stupidity. Feels brightest and best in evening and after sundown. *Worse in the daytime always.* Timid and easily frightened. Startled easily.

Intense aversion to being touched by another, on the hands, hair, or even garments, especially by someone she doesn't fancy; it makes her nervous and irritable.

Craving for alcohol and stimulants, with relief of mental condition after taking same. Alcoholism, insanity, various psychoses, perverted sexuality.

Head. Burning pain in, often in occiput and extending down back. Soreness and burning in neck, extending down spine. Dull pressing pain in occiput and cerebellum, extending to neck and to lobes of ears. Headache from riding in the cars. Eruption on scalp and at hair margins; dry, scaly patches or spots, itching. Perspiration, head, face and neck during sleep.

Nose. Swelling internally, obstruction and catarrh, mostly post nasal. Pressing pains in nose extending to head and occiput. Catarrh worse in the mountains and inland, better at the seashore and sea bathing. Itching, tickling, burning in the nose.

Face. Perspiration upper lip. Chronic eruption anywhere on body, but more especially on face of sore spots, raw, red and non-suppurating. Spots may be slightly elevated or excavated, and exude serum which dries into scabs that child keeps continually scratching off.

Appetite. Craving for alcohol and stimulants, for sour things, hard green fruit. Craving for salt in excess and salty things, for beer and ale.

Excessive appetite, or anorexia. Hiccough and belching. Chronic indigestion.

Constipation, with inactivity of rectum.

Difficult stools as from painful obstruction at anus. Stools difficult, large, hard, ball-like, or tenacious, soft, clayey. Stools passed only while leaning backward.

Diarrhœa and catarrhal enteritis. Obstinate diarrhœa or dysentery in babies of sycotic parentage. Stools horribly offensive, like rotten eggs or cadaveric; of any color; always slimy. These children like best to lie on stomach, often with the knees drawn up beneath abdomen. Diarrhœa from riding in the cars.

The sexual symptoms are those so frequently observed in old, badly-treated cases of gonorrhœa with involvement of prostate, seminal vesicles, bladder, epididimus, or uterus and adnexa, and many such can never be cured without the aid of this remedy.

Impotence is not uncommon after suppressed gonorrhœa, and frequently needs medorrhinum. Sexual neuroses of all varieties. Imperfect and incomplete erections with flaccidity of the glands. Nocturnal emissions; ejaculatio-præcox.

In women there may be excessive desires or dread for intercourse. Insatiable desire with hot flashes, erotic dreams, and icy cold breasts is a complex symptom I have noted.

Intense pruritis; worse thinking of it. Dysmenorrhœa of severe type.

Burning pains in back and hips during menses. Breasts tender and painful, soreness of the nipples. Malignant tumors if any portion of body, especially of genito-urinary system.

Wright, of London and "Opsonic therapy" fame, has for years been publicly demonstrating in laboratory and clinic, not only the curative power of this and other nosodes (called by him vaccines), but demonstrating as well the scientific truth of many of the fundamental precepts and homeopathic principles first promulgated by Hahnemann.

Pharyngeal catarrh and eustachian deafness.

Cough dry, tickling, painful; loose, tearing, worse at night; worse while lying; better lying face downward with knees under abdomen.

Asthmatic and cardiac conditions when patient can rest only in the kneeling position before chair or bed, with arms and chest resting thereon. Often palliative in last stages of phthisis, Bright's disease, cancer, etc., etc. Rheumatic pains worse before a storm; better near the seashore; better sea bathing.

Painful tenderness of heels and soles, worse standing or walking. Burning of feet, with desire to uncover them. Restlessness of feet and legs; must move them continually; better walking.

Restless sleep, worse after midnight. Sleeplessness after midnight.

Sleeping on back with arms above head and knees drawn up. Sleeping on abdomen. The child sleeps face downward with knees drawn up beneath abdomen—rabbit fashion. The child is extremely restless, and crawls all over the bed during sleep, and finally winds up with its head in a corner on hands and knees and uncovered.

Dry, bran-like, scaly eruption in patches on different parts of body; on forearms and legs; in popliteal space; more on extensor surfaces.

Discrete raw spots with red bases, as if dug out with sharp finger nail, exuding a honey-like serum, non-suppurating, and kept raw by the continually scratching off of the scabs as soon as formed.

Cold, clammy skin, with desire to be uncovered. Collapse or prostration with cold, clammy skin and desire to be fanned and to be uncovered. Anæmic pallor. Waxy appearance of the skin, though of a seemingly well-nourished appearance otherwise.

Passive venous congestion of mucous membranes and glandular organs with ultimate overgrowth of both glandular and connective tissue-elements.

Catarrhal inflammation; nasal, bronchial, gastro-intestinal and genito-urinary.

Valuable for euthanasia in malignant and incurable diseases when indicated by similarity of symptoms.

The symptoms of the provers and the symptoms cured in the sick, when compared with the symptoms in patients, dating their illness from gonorrhœa in years past, and all of the foregoing, when compared with symptoms observed so frequently in children whose fathers had the clap before marriage; and the frequent cure of such children with medorrhinum—often given as a last resort, when death seemed certain and all other means had failed; all this goes to prove beyond chance for intelligent argument, the existence of a distinct

disease entity of gonorrhœal nature and origin in acquired and hereditary forms, as was announced by Hahnemann nearly one hundred years ago.

DR. FREEMAN (commenting in the course of his paper): I remember a young lady whom I had been treating for psoriasis for two years unsuccessfully. It seemed to be covered best by arsenic. Arsenic would palliate and almost cure the condition, but it would always come back. She was helped some by graphites, some by mercury. I finally prescribed medorrhinum, and it cleared up the whole case. I was led to think of medorrhinum in her case, partly owing to the fact of the symptoms being so similar to those of arsenic—arsenic failing to relieve—and partly by the fact that her mother had a cancer of the womb which I have been treating for the last four years, quite successfully, apparently, for the woman has the appearance of enjoying perfectly good health at the present time, though she still has her cancer. She is still living, after four years of homeopathic treatment, and when she came to me she had been given up by three or four doctors who had refused to operate, stating the case was hopeless, and she was not expected to live very long. Medorrhinum was one of the drugs given to the mother, the one drug, I think, which did more for that mother than any other. Syphilimum and certain other drugs were useful also. Now, in view of the family history and of the fact that arsenicum seemed to be indicated by the symptoms and failed to relieve, I prescribed medorrhinum. She had this symptom of aversion to being touched; did not want anyone to touch her hands, her hair or garments anywhere; made her nervous and irritable. She had always had that symptom more or less since childhood.

About two weeks ago, a young married woman came in to consult me for ingrowing toe nails. It was a family disease. Several of her uncles had it, and her sister had it very badly, and they all had taken surgical treatment more or less, for years, for the condition. It seems foolish, and I suppose most surgeons would laugh at me for suggesting the giving of medicine for a case of ingrowing toe nails; but this woman had symptoms aside from the local pathological condition, and the symptoms would have been a sufficient ground for prescribing, even if the local pathology had not been. It was one of the worst cases of ingrowing toe nails I ever saw; a suppurating condition, with exuberant granules and intense pain. She said the burning in the toes, extending to the foot and up the leg, was something unbearable. It was so bad that it kept her from sleeping at night, and when she came to my office she wore a pair of old brogans with the toes cut out. Young women do not generally go about in that way except for some good cause. The way she expressed it was, that the burning was so awful that she had to stick her feet out of the window at night to cool them off, and the restlessness which accompanied the burning was so terrible that she could not keep still in any one position night or day, impossible

for her to lie down or to sleep. She cried when she described her symptoms, said it was unbearable and she could not stand it. I gave that young lady one dose of medorrhinum, 45,000, and asked her to come back again in four days. There was nothing much for me to do to the toe except to order her to continue scraping the nail to keep it thin. When she came back in four days, she came back smiling. She had on a pair of stockings for the first time. She said she felt within twenty-four hours a very marked relief of the condition, and the night before she came back, which was the third night after having consulted me, she said she slept fairly well. When I saw her last, about a week ago, the inflammation had almost entirely subsided, there were no more granulations, the suppuration had ceased. The ingrowing condition of the toe nail was still present, but there was practically no pain. The sensitiveness had almost entirely disappeared, and there was no more burning and no more restlessness, and she was able to sleep at night. Instead of boxing the ears of every child that came within reach, as she had done before, she said the irritability had disappeared. This shows the wonderful action of the homeopathic remedy in pathological conditions. There is no excuse for the homeopathic physician not getting acquainted with these remedies and obtaining the advantages that are to be derived from careful prescribing in their cases.

DISCUSSION.

STUART CLOSE: This valuable paper by Dr. Freeman should lead every one of us to a renewed study of the pathology, symptomatology, and therapeutics of inherited, tertiary or latent gonorrhœa. And in doing this, we shall only be, so far as the most of us are concerned, following the lead of the most advanced thinkers in the old school, who are rapidly awakening to its vast extent and importance.

Very few seem to realize, even, that there is such a thing as latent gonorrhœa, or that it is a serious factor in a large number of morbid conditions which have heretofore baffled the ordinary means of treatment; but when we find so able a man as Professor Lydstom, of Chicago, probably the ablest genito-urinary specialist in the United States, expressing himself as follows, it is time for us to wake up.

He says: "The importance of the direct results of gonorrhœa in women can hardly be over-estimated, and has only recently received its just share of attention. * * * Foreshadowed by the labors and once ridiculed theories of the great pioneer in the field—Noeggerath—the researches of modern gynæcologists are developing the most astonishing facts. The more carefully we study pelvic diseases in women, the narrower their etiologic field becomes, and the more frequently they are found to be dependent upon gonorrhœa. Thus, when freed from pathologic and anatomic errors, pel-

vic inflammations are found to be dependent, in the majority of cases, if not all, upon tubal disease; and tubal disease is unquestionably almost always due to gonorrhœa and its congeners and derivations. * * * Thus, metritis, endometritis, salpingitis, hydrosalpinx, ovaritis, parametritis, pelvic and general peritonitis, menstrual disorders and sterility may occur, as well as urethral, vesical and renal disease in the male."

The diseases in the male, and those common to both sexes, in which gonorrhœa has been recognized as a causative or complicating factor by old school authorities, are too numerous to even mention in the time allotted to me for discussion. Of still greater significance to us as homeopathicians, is the recognition by some of these advanced thinkers and investigators of the old school of the fact that all of these dire consequences and complications are caused by the suppression of a primary discharge by local treatment, and injections. Lydston says: "Most complications are due, not to the intrinsic pathologic tendencies of the disease itself, but to irrational general management, or even enthusiastic attempts to cure. The frequency of complications is proportionate to the energy expended in the treatment." He might have gone further, and said that local treatment is invariably pernicious, and that no case ever has, or will be *cured* by such treatment. We need not stop to remind ourselves that Hahnemann, and not Noeggerath, was "the great pioneer in this field," but simply rejoice that the scientific studies and researches of our great exemplar are receiving confirmation at last from sources hitherto antagonistic.

Study of the great proving of Medorrhinum contained in the seventh volume of Hering's Guiding Symptoms, led me many years ago, as it has led many others, to a renewed study of gonorrhœa and its treatment in all its protean forms. No man who has so studied the subject will differ with Professor Lydston when he calls gonorrhœa "the most dangerous of venereal diseases, causing more deaths than syphilis;" nor will he take up the treatment of his next case in the flippant spirit of the shallow sciolist, who considers it "no worse than a cold in the head."

When he has learned from the highest allopathic authorities that over eighty per cent. of men have had gonorrhœa, of whom over ninety per cent. remain uncured, and subsequently infect their wives and through them, their unborn children, perhaps he may have a little more respect for those who have intelligently confirmed, by experience, the teaching which Hahnemann promulgated nearly a century ago in his Theory of the Chronic Miasms. I advise you to hasten your study of what the latest authorities have to say upon the subject of Latent Gonorrhœa, which is synonymous with the Sycosis of Hahnemann. I also advise you, who do not possess it, to get Hering's Guiding Symptoms and study the proving of Medorrhinum, that you may be prepared to call this mighty remedy to your aid, at the proper time, in the treatment of this frightful scourge.

It has a limited field of action, as Dr. Freeman has pointed out, and is to be carefully compared, symptomatically, with its allied remedies, but it fills a place which can be occupied by no other remedy. It is never indicated in acute gonorrhæa, but only in those obscure and perplexing cases in which latent gonorrhœa is a complicating or etiologic factor; and in these its use must be governed by very clear and positive symptoms. It is not by any means a cure-all, to be administered empirically as a specific for gonorrhœa in any stage.

M. R. LEVERSON: A case came within my own experience some years ago that strikingly illustrates the paper. A young man at that time had an attack of gonorrhœa, and was treated by the best physicians of the time, in New Orleans, with the usual remedies, and he was cured, they said. He married, some twenty years afterward, a girl of about sixteen. After some time a child was born. The fontanelles closed rapidly, and the child became feeble-minded. He is now grown, though feeble-minded. Some time after a tumor was noticed in the pelvic region, and the surgeon, Marion Sims, was consulted. He told her an operation would be necessary, but not for the next twenty years; to come to him again if it increased in size. Some thirty years after this, the lady then being nearly sixty years of age, she went to the son, and the son said it must now be removed. The lady weighed probably about ninety pounds. She was about four feet eight inches in height. The ovarian tumors were removed—there were two of them. In one was found, besides a large amount of gelatinous matter, hair, teeth, and the lower jaw, lower part of the femur; in the other tumor less pronounced portions, but still hair and teeth were found. The two tumors together weighed nearly fifty pounds—forty-eight pounds, to be accurate; she had been married nearly thirty years; growing gradually all the time; a lady whose proper weight was little more than ninety pounds. The young man's health, now an old man, could hardly be said to be to blame. He was told he was cured. He would never have thought of marrying had he not believed he was cured. That was one of the most striking instances I ever saw or read of, of the results of suppressed gonorrhœa.

E. WILTON BROWN: A case came into my care, of a woman whose mother had had an ovariotomy performed. The child turned out to be a sufferer from ophthalmia to the extent of losing the vision of one eye. When this child became fourteen or fifteen years old the periods were very painful, and the child never developed into a fair condition of health; was always thin, scrawny and a very poor sleeper. At nineteen, she took cold at a dance, and from that time on never saw a change of weather without severe asthmatic attacks, until at her twenty-fifth year, having tried every physician for miles around, she was persuaded to go and try homeopathic treatment, and the history of the case brought out the facts as stated. After two rather careless prescriptions made at the house the first two times of calling, a single dose of medorrhinum 200; at the third call and a wait

of six days, resulted in a very great improvement in the amount of sleep the lady had within the second night. The second dose of the remedy was given on the seventh day, and a dose once in seven days thereafter for about three months, and to-day the woman sleeps regularly and has not one particle of her asthma.

W. H. NICKELSON: Dr. Close stated that eighty per cent. of men had gonorrhœa and ninety per cent. of those men were not cured of it. Now, if that is so, we ought to know when gonorrhœa is cured. What a horrible thing it is to contemplate that the young women of this country must marry gonorrhœal men in seventy-two per cent. of the marriages. I would like to have someone tell us when gonorrhœa is cured.

HARLAN P. COLE: I am not going to answer that question, but although we are discussing medorrhinum, I see the way the wind is blowing. I was once told by Sigmund, of Vienna, that everybody in Vienna either had syphilis, had had it, or would have it, and it looks very much as if we were going to get into the same situation so far as the other condition is concerned. Now, it seems to me that seventy per cent. of people have not gonorrhœa, and I do not believe that the statements of a man who is making a specialty of a certain thing that he wants to demonstrate to the world, and about which he is over-enthusiastic, ought to be accepted by the general profession as a fact. I do not believe it is true. I heard a physician of considerable experience say once that every leucorrhœa was a gonorrhœa. I think that was just about as extravagant as the other.

J. T. W. KASTENDIECK: I would like to ask, if we do not know when gonorrhœa is cured, how we know when any other disease is cured. If anyone gets well of a disease, and there is no more recurrence of the symptoms indicating that disorder, it seems to me that we must assume that the case is cured. I cannot understand, if we simply make the broad statement that these cases are not cured, how we can say that any case is ever cured. I think that those statements are misleading, at least are exaggerated. I do not believe that that is true.

FREDERICK G. RITCHIE: I want to call attention to a clinical symptom I have noticed as an indication of medorrhinum, and that is a thick crust extending from the nostrils down to the ruby line of the lip. Of course, my experience with medorrhinum has been in eye cases. I had a case come to my clinic at the Ophthalmic Hospital a couple of years ago, a colored child that had a staphyloma of the cornea of the left eye which threatened a rupture. The right eye was affected as well, had ulcers of the cornea. I put a compress bandage on the left eye, and the child was placed in the hospital. It baffled me for some time. I went away on my vacation, leaving the care of the case to my assistants and house surgeon. When I came back the child was in about the same condition, very little change. On going into the ward one day—I do not know why, it was an inspiration—I thought of medorrhinum. I

found no indications for the drug. I gave her first medorrhinum, 200, and repeated it again in about five days. I followed that up for possibly two or three months, with a marked diminution in the condition of the cornea. Afterward I procured from Dr. Rabe here a graft of the c. m., which I gave her. I saw that child, possibly three months ago. The left cornea has flattened out entirely and the right cornea has cleared up to a certain extent, so the child is pursuing her studies in school. I have met with a number of parenchymatous and phlyctenular cases which presented that symptom I have referred to, of the thick, yellow crust extending from the opening of the nostrils down to the ruby line of the lip, and I have taken that as an indication of medorrhinum, and have met with success in every case in which I have tried it.

THE SOLONACEÆ OR NIGHTSHADE FAMILY.

E. WILTON BROWN, M. D.,
MOUNT KISCO, N. Y.

The request of the Chairman of the Materia Medica department has given me an opportunity to express to him, and now to you, an idea that has long been uppermost in my mind in the study of our Materia Medica. I have always held that we practicing physicians should know far more of the source and relationship of the various drugs of which we make use, for the reason that in no other trade or art must a man be so thoroughly conversant with every part and process, so intimately acquainted with every tool and the use thereof, as in the successful practice of medicine. And, not only this, but he must be able at any time of need to direct the manufacture of new tools; he must know in what locality to look for the parts, the material and form by which to recognize them, and when found he must possess the skill and ability to assemble them into the finished product with which he may continue and amplify his work. By this I do not mean that we should all be able pharmacists, but I do wish to impress upon you that we should become so familiar with those few remedies that we have proven from each family, that we may be better prepared to prove those remaining, and thus be enabled to find the good that is in many others of the same family.

The field is very wide and the laborers very few. It must be a question present in all our minds whether we have added as much in the last twenty, nay, fifty years, to the Materia Medica of as good quality as the master, with his few disciples and followers, did in the first, or in any ten, of his teaching? Have we kept the memory of his work as fresh as we should have done? Have we not been find-

ing fault with those provings which have been handed down to us, and at the same time done nothing to improve them, save as for the few faithful who have given us a new, pure proving? I believe that here and now is the time and incentive for us to rally round the new movement and in every way possible to earnestly strive to remove the stigma of "What have you Homeopaths added to science, or to your own Materia Medica?" Have you never been asked that question by some of your Old School friends? If you have not, it must be because your practice is so like theirs that they cannot readily perceive any radical difference between them. Take the position in your professional life that belongs to you by right and inheritance, and let the world know that there is still such a being as a real live Homeopathist. Do this, and when the time comes for any legislation, you will have gained such a distinctive position in the public opinion that your demands, made through your legislative committee, will receive due action.

I firmly believe that we should all know more of the source and distribution, and intimate family connections of the remedies, as well as the symptomatology; for by such knowledge we are better able to form drug pictures, and draw closer likeness, and trace dissimilarities between the several drugs that are derived and nearly allied families. In our search for this knowledge we will come to learn that the drug manufacturer has to be very careful in his selection of the stock as well as the parts of the plants he uses in the preparation of his extracts and tinctures. Many times, adulterations are found in the dried herbs and roots, and in the making of our homeopathic drugs, even when the fresh plant is used, the quality of the tincture depends largely upon the time of the year that the plant is gathered.

This condition of the drug market came forcibly to me two years ago on the 12th of November, when a homeopathic pharmacist wrote me a letter, asking for a number of pounds of rhus tox. The proper season for gathering the rhus is during the time of bloom; but this date was long after snow had fallen, and not a sign of foliage was to be seen. Where did this pharmacist obtain his next year's supply? Did he get from dry leaves a fluid extract, or did a clerk go out and get some of the tender, frost-bitten shoots of the present year's growth? Questions such as this have suggested the line of study which I have outlined for myself, and which I have found a very interesting manner of drug study.

The family of the deadly night shade furnishes many valuable drugs, and has in store for our use a great many more, provided we will exert ourselves to prove them. This prolific group, although it includes over 1600 varieties distributed over the greater portion of the civilized world, has produced only a scant score of remedies and the several alkaloids derived from them. There is no doubt that very many of the other members of the family have some very interesting and profitable symptoms.

These varieties are nearly always herbaceous plants, very rarely

shrub, and with few exceptions have rank-scented and very poisonous foliage, and still more poisonous fruits.

The leaves are alternate on the stems, and the flowers are mostly regularly five-parted and placed upon branchless pedicles; the calyx is persistent, and you will find the stamens inserted upon the corrola or tube and alternate to the lobes. The fruit is a two-celled capsule or berry. As I have said, most of the plants and their fruits are poisonous, except the tomato, strawberry tomato, egg plant, potato and cayenne pepper, which are nearly free from the narcotic or poisonous principles that pervade the family; not that they are free from poison, but that the processes of ripening the fruit in the sun, and cooking, have rendered any active poison inert.

These poisonous principles are found in the forms of alkaloids which vary in the several varieties, and while these do not show any marked difference chemically, yet they act differently upon the human body.

Under the arrangement of the United States Dispensatory the synopsis of the family would be about as follows:

Remedies extracted from root.

Belladonna and Manaca.

Stems and branches. Pichi or Fabiana.

Fruits. Capsicum and Lycopersicu.

Leaves. Belladonna; Stramonium; Hyosciamus; Tabacum; Duboisea.

Seeds. Stramonium; Hyosciamus.

Branched. Dulcamara. S. Tuberaceum ægrotans. S. Pseudocapsicum.

To this number we have added a few others, with only a little good symptomatology, of which the Scopola carniolica and its alkaloids, scopolamine, is very valuable and deserves a good proving. The more important members of this family array themselves around a certain line of physiological action, and are so very nearly identical in their action in many ways as to cause the careful prescriber to look in wonder at the grand results that may follow the application of the law, if he is only careful in the selection of his remedies.

We have good provings only of belladonna, capsicum, dulcamara, hyosciamus, tabacum, stramonium, and meager reports on a few others. Of these, bell., hyos., stram., scopola and tabacum act upon the vasomotor centres. They also, with tabacum and scopola act by paralyzing the termination of the motor nerves in the muscles, and even have a certain amount of anæsthetic or anodyne effect when applied topically over the seat of pain. They are general cerebral stimulants, and are followed by confusion, incoherence and delirium, which in turn, if the drug is used, passes into a state of paralysis. They have a general hypnotic effect which is peculiar to each. They are mydriatics by paralysis of the termination of the third nerve, also paralyzing the accommodation by their action upon the ciliary muscle.

At this point it would be well to study for a moment the effect of the different alkaloids of the allied drugs. Ladenburg and others have devoted many years to the study of the sources of atropine and the allied alkaloids that have a mydriatic action. Atropine occurs in atropa belladonna, and in datura stramonium. Hyosciamine in these and also in hyosciamus and in duboisea. Hyoscine in hyosciamus, and under the name of scopolamine in scopola carniolica. Belladonna in the belladonna root. There are two artificial alkaloids which are derived from either atropine of hyosciamine by heating the natural alkaloids with Baryta water, by which process tropine results, and by a further process homatropoine. This alkaloid acts similarly to atropine, but very actively, so that the effects pass off almost entirely in forty-eight hours while atropine mydriasis lasts for several days.

The first two have a common formula, $C_{17}H_{23}NO_3$; hyoscine and scopolamine are alike, $C_{17}H_{21}NO_4$, and belladonine $C_{17}H_{21}NO_2$. These several alkaloids and their derivatives are so closely related, and have so great similarity one to the other, that to the chemist they are identical in action, although physiologically they are very different. Chemically, the alkaloids from various sources in the same family are alike, but medically they must be derived from the same source to produce the same effect.

References for further study. Annals Ch., Ph. 148, 236, 271. 10 A. J. P. '84, 277; '93, 28; Proc. A. P. A. '86, 392; Am. Drug. '91, 328; Am. Pharm. '94, 409; P. J. '96, 296.

This is forcibly brought to our mind in the effect of the new hypnotic anæsthetic, Abbott-Lamphear method, "in which the manufacturers declare against the use of scopolamine or hyoscine from scopola, regardless of the alleged identity, which we deny in view of the fact that the physiological results are not the same."

When a manufacturing house of some reputation comes out so plainly and strongly in its proclamation of the great difference in the action of several recognized identical substances, and claims a strong difference in their physiological action, would you not expect to see a very strong discussion of the fact as stated by them and the opposition thereto. The fact is stated, and we, as Homeopaths, can readily understand why there may be a marked difference in the several allied alkaloids derived from the various members of this family of drugs that is so prolific in poisonous plants, whose actions in our provings give us a broad foundation upon which to stand, and from which to carefully differentiate the peculiarities of the several remedies.

It is indeed interesting to observe that the alkaloids are so very similar, and to know that the symptomatology of belladonna, hyosciamus, stramonium, with duboisea and scopola, are mydriatic, narcotic, sedative and cerebral stimulants. The first three are very similar in symptoms, but very different in action. As cerebral excitants these three remedies stand at the head of the list producing active and violent delirium. Bell. we usually associate with

the full-blooded man, who is ordinarily very pleasant, but who becomes very excitable, quarrelsome and confused in his delirium. He complains a great deal of the severity of the head symptoms and the congestion of the brain. His eyes are suffused and glistening red; the face deep red or purple, and hot, while the feet are inclined to be cold. The throbbing of the carrotid is very plainly visible. The pain is usually very severe, and produces a feeling of fullness that makes him restless. The delirium with hallucinations, such as seeing ghosts or hideous faces and insects. He bites and strikes and even growls like a dog. Breaks out in fits of laughter and then screams, bites and gnashes his teeth. This violent delirium is due to the fullness of the blood vessels in the brain. The delirium of the hyosciamus patient is more apt to be of the alternating type, a low, muttering delirium with periods of high excitement; and the repeated attacks of the violent type are less and less until the patient lapses into a typhoid-like state. The hyos. patient is not as strong and active as the bell. The latter does not take his medicine because it hurts to swallow on account of the soreness and swelling of the mucous membrane of the throat. Under hyos. he is so suspicious that you are trying to poison him that he refuses the remedies. Hyos. has a very strong, lascivious delirium in which the patient tries to expose the body; she may become very jealous, or jealousy is at the bottom of her present mental state. The mental symptoms of stramonium are similar to both the preceding. The sexual phase being different, and the religious, prayerful state predominant, the patient suffers pangs of conscience, with incoherent talking, delusions and hallucinations, which terrify him. He seems to see small animals, mostly black; bugs, dogs and insects; with mental excitement usually accompanied by violent spasms of the pharynx, so that any attempt to swallow liquids causes choking and screaming; the eyes are protruding, pupils dilated, conjunctiva injected. All these are symptoms of the family group, and only help in the selection of the remedy when assisted by other symptoms. There are not as many head symptoms as in bell., and the patient is not as quiet as in hyos.

The capsicum patient is of a taciturn, irritable temperament, easily angered over trifles; he is apt to be a weak, cold and sluggish subject, one that does not react well after a debauch, or when he has stopped his usual supply of alcohol; he suffers a great deal of chilliness, yet has burning, smarting sensations. In the ear conditions there is a similarity to bell., but here the pain is deep in the bony structure, and under the other the pain is more in the soft tissues; the latter has pains of long or short duration, and sudden cessation while that of capsicum is more constant and boring type. Capsicum has a headache similar to tabacum, of a general, full, throbbing, pressing character but very much worse in the open or cool air, while the latter is much improved going out of doors.

The tabacum patient has a great deal of nervous excitability with lack of mental concentration. There is feeling of self-satisfaction,

even a sense of superior ability to carry out any task that he assumes, but not one that is thrust upon him. The diarrhœa is peculiar with its weakness, and nausea worse in warm room and better sitting in open.

Dulcamara has a similar depressing effect upon the mind, with a pronounced vertigo on rising, and general trembling; there is a paralyzed sensation in the tongue, with paroxysms of sticking, tearing pains in the muscles of the back and extremities. These rheumatic tendencies are decidedly worse upon any change from dry to dampness in the atmosphere or habitation, worse going into cold, damp cellars of refrigerators. The bell. patient has sharp pains, tearing and sticking, that come and go quickly, and the patient moves, even though the pains are severe; he must.

The general type of the whole family seems to be along a close line of symptomatology, and the differences between the several members are easily drawn and used to great benefit.

The idea of this paper is to present the family to the young student in a manner calculated to interest him and arouse in him a desire to study the characteristic differences of each remedy more closely.

The general character of the paper would not allow a closer discussion of the finer, distinctive symptoms of the separate members of the group.

The second object is to draw attention to the vastness of our possibilities and the small amount of labor as yet expended upon the study of our natural drug supply.

Lastly, the fact that substitution and carelessness may give us a remedy that is of less curative value than the one from which the proving was made, upon the statements of which we so much depend for the result of our drug selection.

This series of botanical Materia Medica papers is intended as a foundation for a more complete work of which the papers are suggestive outlines.

DISCUSSION.

J. PERRY SEWARD: Of the greatest value for memorizing are associations and comparisons. In fact, memory without them is impossible. In the study of Materia Medica isolated facts are good on paper, but stay with us only a short time. A list of remedies aggravated by dampness is worth while, if we can remember it, but it is usually memorized, if at all, as in school days we learned the preposition governing the ablative. But let us group the remedies botanically and follow the symptoms through the group, and what an aid to memory we have!

We are not apt to recall that an aggravation from dampness is a feature of belladonna. Let us, however, associate belladonna with dulcamara, and we will no longer forget the modality, and once more the causation of wetting the head will be emphasized.

We are, perhaps unaccustomed to think of the nervous symptoms of capsicum. Since hearing the paper just now and learning, probably for the first time, that capsicum and belladonna are first cousins, we can study anew its irritability, nostalgia and delirium. There will come to us with less surprise the recollection that capsicum is widely and successfully used in delirium tremens, usually in the tincture, and we will know why. The book on Materia Medica most enjoyed during our college days was Farrington's Clinical Materia Medica. In it the remedies were grouped according to animal, vegetable and mineral classes and orders, and many of the strongest, most salient comparisons were based on the relationships thus emphasized. The man whose lectures we most enjoyed, our revered Timothy Field Allen, was a master of botany. How he enjoyed dilating upon the botanical relationships of the remedies under discussion, and tracing the line of similarity between them, and how we benefited! The fascinating descriptions in Clarke's Dictionary of Materia Medica teem with comparisons based on the source of the remedies. How much more they mean to us than mere catalogues of symptoms!

We need in our profession, as the essayist well brings out, men whose hobby is the study of botany in its relationship to the Materia Medica. Too much work of the kind illustrated in the paper cannot be done. I can hardly follow him to the extent of believing that a thorough botanical knowledge is necessarily a desirable feature for the practical physician. This is the age of the division of labor, and we should have masters of the art to provide us with our tools. More emphasis, however, should be placed in studying the remedy on the botanical sources and relationships, that we may the better avail ourselves of the services of our friend Brown, and gain from him to the fullest extent the fruits of his study. Far afield may he ride his useful hobby.

REPORT

OF THE

BUREAU OF PUBLIC HEALTH.

"Clean Milk," - - - - - - - - - - - - E. M. SANTEE.
"The Family Physician and the Sanitary Officer," - - - HILLS COLE.
"A Neglected Factor in Public Health," - - - - HARLAN P. COLE.

CLEAN MILK.

ELLIS M. SANTEE, M. D.,
U. S. Dept. of Agriculture,
WASHINGTON, D. C.

Clean milk has little taste, less odor, and, kept clean, would never sour. The usual taste and odor are due to contamination—principally to fecal matter.

Milk being the one food containing all the constituents necessary to nourish the human body, it is more universally used than any other for infants and invalids. It, therefore, behooves the physician to know each ramnifying detail of its production, handling, and usual methods of contamination.

A quart of milk contains about the same amount of actual nutrients as twelve ounces of lean beef or six ounces of the best wheat bread; but it does not follow that that amount of beef is of equal value as a food if used alone, as it is not equally well balanced.

Milk being opaque, we take that in it which would be instantly rejected if given us in our drinking water.

Nature never designed milk to see the light of day or come in contact with the dust of the air. As man insists upon using milk in an unnatural way, we must pay the usual penalty or make the necessary effort to effectively combat nature; and in passing, I want now to confidently predict that the ingenuity of the scientific men who are studying the milking-machine problems will, in the near future, bring us much nearer to nature than we have ever been before, and result in the saving of thousands of little lives that have annually been sacrificed to the ignorance, the carelessness, or the cupidity of producer, vendor, mother, nurse or physician.

The journey of milk from the cow to the child naturally divides

itself into three stages: (1) Producing; (2) handling by vendor; (3) handling by consumer.

The whole problem may be summed up in two words—*clean, cold.* To produce the highest quality of milk requires healthy cows, properly constructed, clean, well-lighted, well-ventilated stables, the same kind of a milk room equipped with facilities for cooling, bottling and storing the milk, an abundance of pure water, and steam or hot water for sterilizing the utensils. Every time milk is poured from one utensil to another it becomes more contaminated. It should therefore be cooled, bottled and sealed at the earliest possible moment after being drawn from the cow. The seal should not be broken until it is time to use the milk. As it is impracticable to produce sterile milk for ordinary market purposes, and as the bacteria multiplies rapidly between 70 and 90 degrees F., and very slowly below 50, it is manifestly necessary to cool to 50 or below as indicated above. But it is not enough to cool it; it must be kept cool until time of using.

I believe that the time has come when the physician should insist that the milk that is given his patient should come from cows free from tuberculosis; and as the tuberculin test is the only positive method of detecting the presence of the disease in its earlier stages, and it is comparatively inexpensive, there is no valid reason why we should not insist upon it. I am aware that there are two schools of thought upon the subject of the interchangeability of human and bovine tuberculosis; but what well-informed parent will take the chance of one of these being wrong, in selecting a source of supply for his infant's food, and why should the physician take that chance so long as it is so little hardship upon anyone for him to not take it?

After a long, practical experience and careful study of the many milk problems that are before our health authorities and the family physician, who is usually the court of last resort, I am fully convinced that the danger of contamination in the last stage noted above is greater than during the former two combined. The practice of receiving milk in open dishes that have been exposed to the dust of the street all night, or even for a few moments, from large cans that have been opened many times before for the same purpose, cannot be too strongly condemned. I once tried an experiment by rinsing, with sterile water, some of the dishes found along a paved street at five o'clock in the morning, carrying some of the rinse water away in a sterile tube and plating it for bacteria count. Ten samples were thus treated, and the count ran all the way from 330 to 184,000 per c. c., the smallest being from a narrow-mouthed pitcher on a back porch, and the largest from a tin pan on a front steps. Few, if any of these receptacles, had been properly cleansed, and none of them was covered. If people must get their milk from large bulk in the wagon, they can at least set out covered glass jars that have been made *clean.* It is just as necessary for the consumer to sterilize the utensils in the home, as it is for the producer to do the same on the farm. Ordinary dish-washing will not suffice for

the milk utensils. I once saw one of the finest illustrated lectures along this line that should be in every home. While passing a cemetery near Middletown, Ohio, I saw an old-fashioned long-tubed nursing bottle setting on a little grave near a stone which told that the infant had lived about seven months. Inquiry told that the infant had died of gastro-enteritis, presumably from the improper care of the nursing bottle, and the mother, having more than ordinary good sense, probably placed the bottle there as an object lesson to all who passed by on that highway. The solution of the whole problem is education and publicity. There is little use, however, to educate the producer to produce an article that there is either no demand for, or which is utterly ruined while in the hands of the consumer. The sanitary score card has probably done more along this line than all other factors that have been devised in a dozen years. It is being adopted by cities of all sizes, and is proving invaluable to inspector, producer, vender, consumer and boards of health alike; but when it comes to the question of publicity, its chief merit is found. Where the score of each dairy is bound in book form, indexed and placed where the public can see it, the work of the inspector is very greatly decreased, for no consumer who takes the trouble to look up the score of her milkman, will be satisfied to continue to purchase of the lower-scoring places. Touch the vender's pocket, and he gets busy.

A few years ago Pasteur jumped to the conclusion that he had found a remedy for all the ills of milk contamination, in the method of heating to a temperature of 165-185 F., and which has since been known as pasteurization. But as that temperature destroys all the so-called friendly germs, and none of the putrefactive ones, and leaves an undesirable residue, it has gradually fallen into disuse in the production of the highest quality of market milk. No amount of straining, ærating or pasteurization will ever convert a contaminated milk into a desirable article of food, or make it other than what it really is—renovated milk.

It bodes well for the future that the physician is studying this vital problem. Medical societies all over the land are devoting much time to it, and I would urge that they go still further and insist upon its being taught, not only in our medical colleges, but in the schools. The consumer must be taught that the ordinary care of food will not suffice for milk. Teach the child that the best product contains some seed which, in the nearly perfect culture medium—which milk is—will quickly make it unfit for food if not properly handled, and one-half of the present milk problem is solved. Instead of allowing him to imbibe the usual idea that bacteria are intangible somethings that only the great and learned may study or comprehend, let the teacher plate the milk and other things before the class, and let each pupil get a clear idea of the use of the petri-dish and the result and rapidity of bacterial growth.

The United States Department of Agriculture is intensely interested in the matter of better market milk, and is always ready and

willing to co-operate with medical societies or local boards of health in their work along these lines; but I am fully convinced that to the family physician is given the greatest opportunity of all, and it is a crime for him to be either unprepared or neglectful of embracing it.

DISCUSSION.

WM. H. LEONARD: You have undoubtedly listened with a great deal of pleasure and interest to Dr. Santee's masterful paper on clean milk. While it is short and concise, it shows complete knowledge of the subject; in fact he has simply, in his terse way, given you the foundation and superstructure of clean milk, and has left for us to nail on the clapboards and complete his building.

To do justice to his paper would require more time than is allotted to me, but there are some things I desire to enlarge on, and trust to fix in your mind the importance of certain points he has made.

True, the whole problem resolves itself into the two words clean and cold. It means cleanliness in minute details. Not only must the barn, milking room, and cows be thoroughly cleaned, but the utmost care must be taken by the milker in preparing himself and the utensils used in milking, to see they are as nearly aseptic as possible. He should also be taught what to avoid, and why, as much as the interne or nurse in an operating room, for the reason that the doctor states, "that nature never designed milk to see the light of day or come in contact with the dust of the air."

The effect of cold or ice on milk is at present an undecided question. This we do know, that milk when quickly cooled, bottled and sealed, and kept at a temperature below 40 degrees F., on the second or third day has a marked drop in the bacterial count, remains at the low count for a day or so, and then gradually ascends again, maybe taking four or five days before reaching the original count made by plating shortly after milking and cooling. Some claim that this is due merely to a suicidal action on the part of the bacteria that come from the teat of the cow, owing to their not having the proper conditions necessary to life. Others claim, however, that it is the direct effect of the ice.

To give you some idea of the drop made in the bacterial count, I can quote from some experiments made along this line. From a quart of milk, a plating was made shortly after bottling, and then the bottle was immediately recapped and put in ice, and plates made each succeeding day. Original count from one bottle 2,150 bacteria to the c. c. (this is an average of four plates at dilutions of 1/10 and 1/100 in agar and held at room temperature for five days), second day, 1,660 to the c. c.; third day, 390; fifth day, 1,330. Another sample, original count, 2,340; second day, 1,880; third day, 420; fifth day, 1,750. These two are examples of marked drop on the third day. All samples do not show the same decrease in such a marked degree

nor as soon, as can be seen from the following: Original count, 10,410; second day, 8,500; fifth day, 4,480; or, original count, 9,270; fifth day, 3,120. I regret that I cannot give you a positive statement as to the "why" of this condition, but Dr. Moak, of the Kings County Commission, Professor Harding, of the Geneva Experimental Station, and myself are working on this question, and hope to be able to make public some definite deductions and conclusions before long. I merely bring out the point to show that bottled milk is the only manner in which milk should be allowed to come into your cities, and that it is really better milk on the third or fourth day, if properly iced and kept so, than on the day of milking. Also to explode the idea that milk three or four days old is stale ana unfit for use. Why, milk that had an original count of 97 bacteria to the c. c., thirty days from that date, having been in ice all the time, and seal unbroken, was perfectly sweet and fresh, and had but a count of 9,742 to the c. c. This only goes to prove Dr. Santee's statement, that "clean milk kept clean and cool would practically never sour."

Ordinary market milk is unfit for consumption, and is a direct menace to the health of the community, and most assuredly, can milk is an abomination in the sight of God, and should be in the sight of man. We, as physicians have left this important subject alone too long. Millions have been spent to procure, if possible, pure water. How much has been spent to procure clean milk, which is of equal importance, especially to children and invalids? This brings us to two points made by Dr. Santee:

First, that the danger of contamination is as great, if not greater, by the consumer, than by the producer or vender, and

Second, that education of the public is the most important factor in procuring clean milk. The rectifying of the first resolves itself into obtaining the latter.

Gentlemen, how many of you are having proper care taken of the milk used in your homes? When you stop and think that milk is nearly a perfect culture medium, you can readily see the danger that may arise in the ordinary way of handling milk. We have simply digressed from the old Mosaic law, when we place uncovered vessels out to receive our daily milk supply; for they were taught that "every open vessel, which hath not covering bound upon it, is unclean." Numbers 19-15.

Can milk should not be permitted in your cities, for two reasons. One, as it is impossible to keep it at an even low temperature, an essential in clean milk; and the other, the easy manner of contamination every time the cover is removed and the milk exposed to the dust of the air, and is agitated to obtain a quart or so from the can. Keep your milk at home sealed; only take such portions from the bottle as you think you will require for the meal, putting it in a sterile receptacle, recapping your bottle, and on no account, if there is a remainder after the meal, allow it to be poured back in the

bottle. Throw it away; do not run the risk of infecting your clean milk.

I wish to heartily endorse Dr. Santee's idea, that the subject of clean milk should be taught in medical colleges and in the public schools. It seems to me that we can make a ten strike, as a society, by going on record as demanding the above, and making a strenuous effort to obtain the same. Create a demand for clean milk; foster a willingness to pay a slightly increased price necessary to its production, and the producer will meet you more than half way.

Why do we need clean milk when pasteurized milk, like the poor, is always with us? It is much cheaper to advertise, and delude the public with the idea of safety in pasteurized milk, than it is to rectify the ordinary methods of producing market milk, so that clean milk may be produced, and placing the safeguards around it necessary to keep it clean. What does pasteurization do? As Dr. Santee says, it removes the friendly germs, especially the lactic acid bacteria, which are the natural safeguards to the milk. It has changed it from an acid to an alkaline media, in which the putrefactive bacteria, which were not killed, grow more rapidly. Let us see what some of the counts, obtained by plating pasteurized milk, are, and see if the process has done what it claimed for it.

The following counts are made from samples of pasteurized milk taken from wagons in your own city of Brooklyn, which were made for me by Dr. Harris Moak, Bacteriologist of the Milk Commission of the Medical Society of the County of Kings: 110,000, 87,400, 59,800, 94,700, 309,000, 119,040,000. These are all counts to the c. c. From these figures it can be seen that pasteurization does not always do what is claimed for it but on the other hand, as stated above, makes a media in which the worst form of bacteria thrive. I would much prefer to take my chances with ordinary market milk, high count and all, than with so many quarts of renovated milk, which should be labelled as such before being sold.

I desire to go further than Dr. Santee in regard to tuberculosis in cattle, for I believe that the consensus of opinion is that human and bovine tuberculosis are interchangeable; that they vary only in type, bovine being much more virulent. We certainly should demand and insist that all milk coming to our cities should be from non-tubercular cows. Every dairy sending milk to cities should be required to send to the commission or local boards of health, every six months, a certificate from a reputable veterinary that the herd has been tested and is free from tubercular cows. This should be done for two reasons; first, to help prevent the spread of the white plague, and second, to prevent the spread of tuberculosis in cattle, which is really appalling.

We take every precaution to try and isolate patients suffering from this disease, making strenuous effort to maintain strict sepsis, which is laudable, while we allow tuberculous milk to be peddled and sold by the gallon, without any seeming effort to limit its sale. The time is past when we can look upon this question lightly. It is

one we must face. We owe it to humanity to stamp out, if possible, tuberculosis in cattle. Pasteurization avails nothing, for rabbits rapidly become tuberculous on being fed on boiled tubercular milk; therefore, we must devise some means of disposing of the affected cows after adequate compensation to the owner.

Gentlemen, when I see cases of enterocollitis rapidly cured by simply placing them on certified milk, modified according to age, and flushing the colon with normal saline solution; and when I see a patient, a lady who is a brilliant writer and composer, a nervous wreck, suffering from gaseous indigestion, who has been treated by a number of eminent men, even trying the ordinary milk diet without results, gain four pounds in less than three weeks, when placed on certified milk and cream, with the addition of a slight amount of fruit and baked potatoes, and all symptoms rapidly disappearing, I begin to realize some of the benefits to humanity from clean milk. It therefore behooves us to make an united effort to assist the local boards of health and United States Department of Agriculture in procuring clean milk for our cities.

DR. NICKELSON: We have heard from the producer, and now would like to hear from the consumer. We have with us Dr. Moak, who has charge of the Milk Commission work of the city of Brooklyn, who will now address you.

HARRIS MOAK: I am very glad to have heard Dr. Santee's paper, which is complete, and has a great deal in it. I am very glad to have heard Dr. Leonard's discussion, which appeals to me also as being a complete and careful treatment of the question, and a very good paper, indeed. I am prepared to say only a few words, on a pretty short notice, regarding certified milk. There is some confusion yet in the minds of the public as to what certified milk is. Even some physicians do not realize or understand exactly what it is. One of the most reputable surgeons in a neighboring city wrote not long ago and wanted to know where he could get some good "sterilized" milk, meaning, of course, certified milk. The word is often confused with "Pasteurized" in the public mind. Certified milk means simply clean milk, kept cold and in the most natural state that we can get. We get as nearly back to nature in all our efforts as possible. The milk is not modified, treated, "doctored," or changed in any way, so far as we are able in our efforts.

The efforts of the Milk Commission are put forth mainly in the country, where the milk is produced. We do all we can to get milk to you in as natural and good condition as possible. But all our efforts, often, are of no avail. In a large sense, in practically an entire sense, our responsibility ceases when the bottled milk is delivered to your patient or other consumer, and the treatment that milk gets in the home is often far from what it should be, as has been emphasized both by Dr. Santee and Dr. Leonard. I have had occasion to investigate a good many complaints regarding milk, and, of course, the certified milk, and have found that very often the physician does not appreciate how milk should be handled. We find that

often a physician orders the mother or the nurse to modify the milk for the little baby, and one of his particular statements will be in that modification to use so much boiled water. The chances are pretty nearly even, as yet, that that mother or nurse or attendant upon the baby will use fresh hot boiled water and pour it into the desired quantity of milk, whether it is certified milk or any other kind, bringing the whole mass up to a temperature where bacteria thrive most wonderfully. Boiled water and ice-cold milk make a very beautiful temperature for the thriving and growth of bacteria. Often milk is modified in that way, put into the bottles required for feeding, and then those bottles set into the ice box. If you would instruct your users of milk, those who modify it, to boil the water, which is all right, but to cool that water down to at least room temperature, or set the vessel of boiling water into another vessel containing ice water, and cool it down so it is good and cold, and then modify your cold milk with cold water, put the requisite amount into each of the nursing bottles, and not trust merely to the air of the ice box, which in summer time is pretty warm, as you will discover, if you will take the pains to take the temperature of a good many ice boxes. If these instructions are carried out a great deal of trouble can be avoided. A good way is to set those bottles all together in a small kettle, an agate ware kettle, for instance, and crack up some ice, and put some fine ice right in and around those bottles and keep that milk in the same condition, practically, as it is delivered to the consumer. You will find that a whole lot of trouble and annoyance will be saved if you will be careful always to instruct your people how to care for milk after they get it into their possession. It is a common thing to see milk standing about in warm kitchens and elsewhere until noon, and sometimes the milk bottle never goes into the ice box. It is a great part in this work for better and purer milk, to get physicians to help us educate people as to how to care for milk after it comes into their hands. As I said before, our efforts are mainly, if not nine-tenths, in the country, where the milk is produced. What we do in the city is simply to see that the milk is kept fairly well iced, which of course the dealers are mindful of, as a rule. The great majority are more or less anxious to deliver the milk to their customers in just as good condition as possible; that is, well iced, and that is the main thing that the dealer has to do in the city with regard to milk—to keep it well iced and deliver it at a proper hour. But our main effort is in the country. Our best efforts, however, often avail nothing simply because, as I have said, the milk does not receive decent, respectable care at the hands of the consumer.

M. R. LEVERSON: One important consideration seems to have been lost sight of—that probably 19/20 of the people of any of our large cities can no more afford to take the care which is spoken of than they can go to the opera. Poverty is a great difficulty in the way. Now, the papers which were read to-day were exceedingly suggestive, and I was very much pleased to find that official medicine, as

we may say, seems to be awakening to the absolute humbug of Pasteur and what belongs to him. The grossest plagiarist, the greatest charlatan in the entire history of medicine, was Louis Pasteur, and I entirely agree with what was said in condemnation of Pasteurized milk. The man from whom most of the work of Pasteur was plagiarized was Dr. Bechamp, and if you will read Bechamp's work upon milk, you will find that all of the rest that has been got since is not much. He exhausted the subject. The fact is that Bechamp discovered the functions of certain small bodies to which he gave the name of microsems. These develop into bacteria, and are no more injurious than the bread which you ate this morning for your breakfast; but the bacteria are apt to become diseased, and disease the tissues, and when that is the case they do mischief. Of course, I cannot go into that subject now. Permit me to ask all present to study the works of that neglected genius, Professor Bechamp, the man who made the greatest discoveries of all times in medicine except Hahnemann, and the man who laid for the first time in the world's history a true foundation for physiology, pathology and biology.

MAURICE C. ASHLEY: I have been very much interested in the papers and discussion on clean milk. Inasmuch as I dispense about a ton and a quarter of milk a day, and have been trying for some years to get clean milk, I have naturally been more than a little interested in this subject, and especially in some of the suggestions about how clean milk may be obtained. One suggestion was that all cattle be tested with tuberculine and certified every six months. If that is done, how under heaven are we going to know that tuberculosis does not develop in three days after the test, or three months, or four months? How are we going to prevent the farmer from buying another cow, or several other cows, and adding them to his herd the next day after the test? How are we going to know that they are not tuberculous? We cannot prevent it. The getting of milk absolutely clean to the consumer is an absolute impossibility, even in Orange County, where milk is produced by the thousands of quarts. It does no good to tell a man what you want him to do. You must have over each man another to stand over and watch him and see that he does clean the utensils and his person and the cow's udder, as directed. If he does not do it, you dispense with his services. You get another man, and he is no better. So I believe it is utterly impossible ever to reach that point where you are going to get absolutely clean milk.

F. EDWARD HOPKE: I would like to digress one step, if I may be permitted for a moment, to ask a question of Dr. Santee relative to the character of milk. Years ago, physicians made urinalysis but very infrequently, and this effort for good milk will not be successful in affording the greatest benefit to the public until the physician is able to tell in his office or at the home just what kind of milk supply he is using. I mean with respect to the percentages of the proteid, and so on; and I should like to ask Dr. Santee what meth-

ods he has to offer the individual physician in his daily work for examining the milk that he has to have for his patients, if there is any apparatus or any method which can be advised for an office examination of specimens of milk that are under doubt or consideration.

DR. SANTEE: The butter fat in milk is of course a very important thing for the doctor to know, if he is going to modify his milk. so that he may ascertain what he is feeding his baby. That information is usually furnished him by the local authorities, but if he is not satisfied with their examination, he can very readily make his own by the Babcock test, which is known about by nearly everyone, I think. It is a very simple mechanical operation, that anyone could learn in a few minutes, and the apparatus is very inexpensive. I think perhaps $2.50 would purchase a small Babcock apparatus, and then twenty-five cents will purchase the two bottles, and a little sulphuric acid to go with it will complete the whole outfit; so that a good deal less than $5 would give any physician not only the test for the bacteria count, but also for the proteids. Of course, after knowing the butter fat, the solids are computed. No machinery is necessary for that.

There was one point touched upon by Dr. Leonard that I wanted to speak of, for the reason that it is liable to create some confusion; that is, the requiring of a veterinary's certificate. But before going into that, have I answered your question, Doctor?

DR. HOPKE: No, you have not. I know about the Babcock test, and all that, which is in the books at present. My idea was to ask you if you had anything in addition to offer that might be utilized by the physician in his office.

DR. SANTEE: There is nothing else so good as that.

DR. HOPKE: I mean particularly for the estimation of the proteid. That is estimated simply from the amount of fat that is present in the specimen, and it is a negative, indirect estimation; it is not a positive, definite estimation; so that a physician is left pretty much in the dark as to what the percentage of proteid is in any given specimen of milk that he is employing. Now, the idea is, if we had some method by which we could calculate the definite percentages of these specimens of milk, we would be in a far better position to know how to modify that milk and what to give the baby.

DR. SANTEE: That takes you so much further into the chemistry of milk than the average physician can go, that it would be useless for us to go into it. You will have to depend upon your specialist for that.

DR. LEONARD: Simply obtain the specific gravity of your milk, Doctor. There are tables on the market that you can procure, and you compute the amount of the proteids from that. It is accurate to within about one-tenth of one per cent.

DR. HOPKE: I thank you.

DR. SANTEE: In regard to the other matter, spoken of by Dr. Leonard, the tuberculine test, he speaks of requiring a certificate

from a veterinarian. That is all very well as a make-shift to start with, but it has not worked out well in practice, for the reason that veterinarians, like physicians, sometimes have their hands behind them, and are not always very scrupulous as to how they do things. Wherever that has been tried, it has been a failure, and the only method that has ever been successful in getting positive information in regard to the tuberculine test, has been where the city employed its own veterinary, and he, depending upon the accuracy of his work for the retention of his place, is not nearly so apt to go back on the city's interests as the man who is working in the interest of the farmer who employs him, and many times in his own as well, by getting a fee for a clean bill of health. We always recommend the city to employ its own veterinarian rather than to accept the veterinary certificates of Tom, Dick and Harry.

Just a word in reference to what my venerable friend here (Dr. Leverson) said in regard to the expense of caring for milk in the home. If you have not ice, everybody has running water, and running water is so much colder than the air of the room that milk can be infinitely helped by placing it in a dish of running water where ice cannot be had. Anyone can do that.

THE RELATION OF THE FAMILY PHYSICIAN TO THE HEALTH OFFICER.

HILLS COLE, M. D.,
NEW YORK CITY.
Medical Expert of the New York State Department of Health.

The science of preventive medicine is making great strides in this country. We are yet, of course, far behind some of the European countries in this respect, but if we notice the pace that is being set, we must agree that the time is not far distant when this country will be the peer of any if not the superior, in matters of sanitation. What we can do is shown by the story of the control of yellow fever in Havana and the wonderful work carried on under the supervision of Col. Gorgas in the Panama district.

Before, however, the best results can be obtained we must have better co-operation between the general practitioner and the health officer who stands as the guardian of the public health. At present there is all too frequently a good deal of friction between the family doctor and the public health authorities.

One or two factors contribute to this. Politics has entered into the appointment of the health officer in the majority of instances, and he is often not the best educated physician in the community. The tendency, then, is for the family physician to resent the exer-

cise of authority by him. And it often happens that the health officer is not as diplomatic as he should be in exercising his important duties.

As to the matter of education, the time will undoubtedly come when the physician seeking appointment as a health officer must show evidence of special qualifications. He must have had practical and theoretical training in the work which he will be called upon to perform. At present no such special instruction can be had in any institution, and moreover, the emolument offered to him in most instances is so small, that the physician hardly feels warranted in spending time and money in acquiring this special information. Take the State of New York, for instance; out of its 1,500 health officers there are not 100 who have to take a civil service examination because their compensation exceeds $300 per annum.

The family physician can and should co-operate with the health officer in two ways: First, by promptly complying with the State and local regulations in regard to matters of public health; second, by interesting his patients is such matters and securing their intelligent co-operation in promoting sanitation and the prevention of the spread of disease. At present, there is far too much indifference, both among the physicians and the laity. There are signs of reform, however. The campaign against consumption that is being vigorously waged with the help of the people is making them wide awake to the importance of preventive measures, and the public lectures on health topics now given in many cities, are well attended and attentively listened to.

This is a very hopeful sign. We can never get the best results from public health laws if we have to force them upon an unwilling people, or to exact penalties for their infraction from those who do not comprehend the benefit of them, to the community, if not to themselves individually.

In this campaign of education the family physician has a great part to play. He is a trusted adviser, and a word now and then, the distribution of a pamphlet, an invitation to a public lecture, or what not, will mean much. Too often, however, we see the family physician deliberately ignoring local regulations or conniving with the family in the ignoring of them. Cases of communicable disease have not been reported because the physician feared he might gain the ill will of the family if he were responsible for the institution of quarantine regulations.

Sometimes the physician is not in sympathy with the regulations, and he allows his personal views to override those of the majority of his professional associates, which form the basis of public health regulations. This has been the case especially in the matter of vaccination, and the more recently introduced registration of cases of tuberculosis. This is not the place to enter into the discussion of the value of such measures, but I do want to insist that the proper procedure for the doctor who disagrees with them is to state his case as strongly as he can to his professional brethren, and seek

to convert them to his way of thinking; and not to set a bad example and tend to create in his patients a contempt for all health ordinances by refusing to carry out the prescribed regulations.

We have many excellent ordinances tending to diminish the spread of tuberculosis. The physician, above all, should be careful to observe them. He should never be known to spit on the sidewalk, or in a public conveyance or building, and he should also see to it that all the members of his family are equally particular.

The family physician should also always be prompt in reporting cases of communicable disease. Only those doing public health work fully realize the importance of this. If there is any doubt about the diagnosis, it is safe to err on the side that will give protection to the other members of the family and to the public. Only recently I ran across a case where a mistaken diagnosis of erythema led to three members of a family, including the father, being laid up with scarlet fever, with considerable financial loss as the result, to say nothing of the discomfort and suffering and anxiety that these cases of sickness brought with them.

State and local boards of health offer laboratory diagnosis in diphtheria and typhoid fever and the family physician should avail himself of these aids. It is not claimed that such a diagnosis excludes or does away with the necessity for a clinical diagnosis. The laboratory worker seeks to confirm the clinical diagnostician's conclusions, and to enable the physician to be the earlier sure of his diagnosis and to take the necessary steps for the protection of the public.

We speak of typhoid fever as a water-borne disease, and the medical profession is unanimous in urging the filtration of water used in large municipalities. Is it not true, however, that the physician is to blame in the first place for allowing the contamination of the water supply by his patient's feces? Had he thoroughly explained the situation to the family and insisted upon the proper disinfection of the stools and urine and their proper disposal, the subsequent epidemic would not have occurred.

In caring for cases of communicable diseases how many physicians are as careful as they should be? How many make it a practice to wear a special enveloping garment when entering the sick room, and to disinfect their hands before leaving the house? How often does the family physician hesitate to tell the patient or his friends that he has tuberculosis because to do so may seem like sounding his death knell? And in the meantime no special precautions are taken at home or at the shop, and he may be the innocent cause of spreading the disease.

A word has been said about prompt reports of cases of communicable disease. Improvement is also needed in the promptitude and accuracy with which certificates of birth and death are filled out and filed. The majority of states in this country have very inadequate regulations as to these details. The collection of these cer-

tificates is not a mere perfunctory performance; some valuable data can be secured from accurate documents of this character. And it should be borne in mind that they are public documents. Transcripts are often brought forward as evidence in the courts and inaccuracies are apt to bring ridicule upon the medical profession, if not upon the individual responsible for the certificate.

A few remarks upon the defects most frequently seen will not be out of place. A certificate should be written in black ink. The use of rubber name stamps, of black lead or indelible pencil is unsatisfactory on a public document. No mutilated, illegible or inaccurate certificate should be offered to the authorities. There should be no erasure, interlining, correction or alteration of anything printed or written on the certificate. If a mistake is made, another form should be filled out correctly. Every question should be answered in some way. Where necessary, the word "unknown" should be written. If a blank space is left, the statistician may conclude that the corresponding question was overlooked. Never use dashes or ditto marks to fill in any part of a certificate.

In regard to occupation, the rules given in the U. S. Census pamphlet should be strictly followed: Occupation should be reported for all who pursue some gainful employment. Married women and children living at home and not engaged in some remunerative employment should be returned as having "None."

The general principle is to bear in mind what labor the deceased performed, without regard to the place or the person for whom he worked. Particular care should be taken to express the occupation in such a way as to prevent it being confounded with other occupations. Distinguish between farm laborers, railroad laborers and other day laborers.

Married women, female heads of families, or other women who are employed in domestic duties only in their own homes, should not be reported as "housekeepers," "housewives," "housework." These terms should be reserved for those who receive a monetary compensation. The occupations for all who work for money should be reported, and the word "None" should be written for all over the age of ten years having no gainful occupation.

In death certificates the most important information is the cause of death, and yet it is surprising how carelessly this question is answered. Above all things be specific. I have seen a certificate with the alleged cause of death—"Disease of the throat resulting in choking to death;" and another where the age was given as sixty-nine, and the cause of death was stated to be "congenital malformation."

If the cause of death is one under which certain circumstances would call for an investigation by a coroner, it should be made evident on the certificate that no such inquiry is needed in the public interest, if such be the case. Among such cases may be mentioned abortion, cellulitis, childbirth, erysipelas, gangrene, gastritis, men-

ingitis, metritis, miscarriage, necrosis, peritonitis phlebitis, pyemia, septicemia, sudden death, surgical operation, tetanus and "unknown."

Other unsatisfactory causes of death are abscess, accident, amputation, anæmia, asphyxia, asthemia, brain fever, cancer, congenital debility, congestion, convulsions, debility, dentition disease of the brain, lungs, etc., dropsy, exhaustion, fever, fracture, heart disease, heart failure, hemorrhage, inanition inflammation mal-assimilation, marasmus, milk infection, natural causes, old age, paralysis, spinal disease, stillborn, when an age is stated, stricture, suicide, tumor and typhoid pneumonia.

As already intimated the family physician can be of infinite help to the sanitary authorities, to the community and to his patients, by taking an active part in educational campaigns and by active participation in hygienic reforms. He should counsel parents to impart the rudiments of sex knowledge to their children; he should insist upon the importance of being satisfied of the freedom from gonorrhœa or syphilis of the would-be bridegroom; he should teach in season and out of season the value of fresh air, that "night air" is far less harmful than "close" air or air that has been superheated; he should preach temperance in all things, in food as well as in drink; he should warn against patent medicines; he should advise against forcing children in school; he should be amongst the foremost workers for all sanitary reforms; for clean streets, for the abolition of unnecessary noise and the abatement of other nuisances, for the preservation of the purity of our rivers and lakes, for pure food, for the creation of public parks and playgrounds, for improvement of the homes of our working classes and of the shops in which they work, for fair wages and the abolition of the sweat shop, for the installation by employers of every device to protect the workman from accident.

The physician is not only the trusted counsellor of his patient; he is a factor in the public welfare. He should take the initiative in all such matters of public interest as his peculiar education and training fit him to assist in with special helpfulness. Above all things, petty jealousy of the health officer or a difference of opinion should not hold him back from doing everything that his professional obligations impose upon him.

DISCUSSION.

T. FRANKLIN SMITH: If I understood the essayist aright, he made the statement that where there was any doubt whatever in any case of communicable disease, the benefit of the doubt should be given to the outsiders who might become victims of that infection. I do not know whether I am correct in that or not, but if I am, I should certainly take exception to a thing of that kind. There are two

sides to a question of that kind, it seems to me. It is not simply those who are in danger of having the disease from communication who are to be looked after, but there are also the patients themselves who are to be protected from the inoculation of what may become a dangerous poison. I have in mind a case that occurred within a year, of a young lady with whom I had been acquainted for a number of years, a school teacher, who was taken with violent sore throat. I did not see the case, but her mother advised her to call upon the family physician, who was a Homeopath, and he said he was not very certain whether it was diphtheria or not, but advised the patient to come back next morning to his office, instead of calling upon her. She did this. He examined the throat again, and told her that she undoubtedly had diphtheria, that he would take a culture and send it down to the board of health; but in the meantime it would be necessary, in order to protect herself and the members of the family, to submit to the inoculation of antitoxin, which she did. The next day when he called to see her he told her that he had been mistaken in regard to the trouble, that it was not diphtheria at all, as the culture had proved there was no bacilli in it. For three months that girl was confined to the house with ulcers which broke out within a week or ten days, as the result of the inoculation with antitoxin. I think in that case the benefit of the doubt should have been given to the patient.

A NEGLECTED FACTOR IN PUBLIC HEALTH.

HARLAN P. COLE, M. D.,
NEW YORK CITY.
Consulting Orthopedist, New York State Department of Health.

Sanitation in its widest sense is the application of the sciences and the engineering and building arts to the betterment of the public health. A citizen is the greatest possible asset to a community when he is in the best possible physical condition, and the expenditure of public moneys and the employment of public servants for the attainment or preservation of this perfection, is justifiable on economic grounds, to say nothing of the humanitarian aspect of the case.

It may seem to savor too much of socialism to say that all sick persons shall be cared for at the public charge, but we have already advanced somewhat in this direction. At any rate, the employment, at the public expense, of the proper means for the prevention of the spread of communicable diseases, is accepted as a public duty. We spend public money in investigating the causes of diseases, and the public purse is drawn upon to improve or maintain the purity

of water and food supplies. We have our medical inspectors of schools whose duty it is to see that the pupils are in such physical condition that they can use for the best or assimilate the educational advantages gratuitously supplied by the State or civic authorities. This, I take it, is the meaning of the testing of vision and hearing, customary for some time past in the largest cities of this State, and recently extended to the schools of our incorporated villages through the efforts of Dr. Schenck, our worthy president, who is the consulting ophthalmologist of the State Department of Health.

There is, however, I believe, one factor that goes to make for the physical imperfection of the citizen, that has hitherto been overlooked by both educators and public health workers. I allude to deformities and deviations of less degree in the lower extremities.

General physical exercise has long been considered a matter of vital necessity, and an important part of the curriculum at school. Increasing attention has also been paid to the relative height of seat and desk, and their effect on the physical development of the child, particularly as to the possibility of an improper adjustment producing a habit curve of the spine.

Personally, while I believe that, because the child can only do the best work possible when he is comfortable, the seat and desk should be adjusted to his special needs, I am not inclined to regard a maladjustment as a potent factor in producing spinal curvature, for it seems to me that with the varying work a child is called upon to perform, and his natural restlessness, he does not stay long enough in any one position to develop a curvature of the spine.

Physical examination has been specialized to the extent of locating imperfections in the relative development of the various muscles of the body, and special exercises are prescribed to improve individual parts. The study of dancing and deportment has been encouraged, and of late the so-called military attitude, the habit of turning out the toes in standing or walking, has been criticised, particularly by orthopedic surgeons, as a common cause of imperfect walking ability and foot weakness.

Notwithstanding all these precautions, if you will stand at the door of any school as the children are being dismissed, and carefully watch the feet and general poise of the pupils, you must notice that few of them are perfectly balanced.

And what is true of the child is true of the adult. Dressmakers and tailors have to pad the hips and shoulders of the clothes of the majority of their customers. All the stores that sell shoes sell some device to put in the shoe to overcome a weakness that the shoe either produces or does not prevent, and that all the precautions adopted in early life and all the efforts at physical culture have not obviated. Seldom do we see on the street a pair of feet both of which stand upright; and a large proportion of those who have been much on their feet walk with stiff ankles and with their toes turned out to an exaggerated degree, and as if they wished that

every step they took would be their last. A Chicago shoedealer recently stated in a trade paper that he sold arch props to about one-third of his customers. Painful corns and bunions are the rule, rather than the exception, and the chiropodist reaps the benefit.

But the trouble does not end here. At the civil service examination of candidates for positions in the police department of New York city, out of 3,745 examined last year, 1,635 were rejected for medical reasons, and twenty-five per cent. (410) of these owed their rejection to disabilities in the lower extremities. The grouping was as follows: Flat foot, 204; varicosed veins, 96; bunions, 20; hammer toe, 13; knock-knee, 11, and the balance for minor conditions. This grouping is according to results; the cause of all is the same, viz., the imperfect use of the foot, largely due to faulty shoes.

In the case of the fire department, the proportion is about the same.

In other respects, these candidates might have proved splendid material for these public services; and it is a public misfortune and a public loss that so many citizens are thus disabled, for I am sure that in many walks of life—waiters, postmen, street-car motormen and conductors, shop assistants, nurses and dentists among number—imperfect service is being rendered; time is lost through absence from work, and otherwise useful employees have to abandon their occupations because of disabilities in the feet and legs.

And physical culture, as ordinarily understood, does not provide the remedy, for we find that many teachers of physical development and of dancing have the same troubles in exact proportion to the length of time devoted to their work.

Does it not, then, behoove physicians, and public health workers, especially, to look into a physical defect so widespread, and in the aggregate of so serious financial importance, and find a cause and point the remedy?

In order that you may not think that I magnify the difficulty, I quote from an article by Charles P. Frischbier, M. D., in the *Medical Record.*

"The relatively large number of cases coming to the clinic of Professor Collins at the New York Post Graduate Hospital, for the relief of pain in various parts of the body, in whom, after careful examination, flat-foot or weak foot is found as the sole attributable source of pain, has led me to believe that a discussion of this subject might be profitable.

"Although the pain of flat-foot is usually of the feet and legs, it may be of any part of the body, for I have seen improvements of flat-foot in most instances followed by a cessation, or at least amelioration of aches and pains in remote parts of the body.

"From an analysis of 125 cases, I feel justified in regarding congenital or acquired weak and flat-foot a source of irritation capable of causing widely scattered pains and discomfort, to the degree of depression and exhaustion, in particularly susceptible subjects.

"In all cases and all degrees of flat-foot, we naturally expect to

find local pain or tenderness about the feet, ankles, or legs, and these sensory disturbances frequently are not commensurate with the development of deformity, so that in the beginning destruction of the joint, long before any noticeable change of outline, the pains are apt to be most severe and continuous.

"Quite frequently, also, the pains appear localized at first about the knee or hip joints, and later travel downward to concentrate themselves about the member at fault.

In fifty-six cases, pains extended to the thighs; in forty-seven there was pain in the buttocks and lumbar region; in thirty-nine cases the pain was first felt in the hips, thighs (anteriorly) and inguinal region; in thirty-four cases there was backache up to the shoulder blades; in twenty-one extreme general irritation, followed by depression; in seventeen there was a pain in the back, also right or left arm; in four cases there were restlessness, insomnia, pains worse at night, in opposition to the general rule that resting the feet relieves pain.

"* * * Weakness is more pronounced at the inner side of the foot and ankle; there are strain and ache of these parts and the calf; coldness, numbness, hyperidrosis, all aggravated by atmospheric changes, are noticed.

"Discomfort and tire after short walks necessitate frequent rest, during which the joint components reposit themselves in the normal order, shortly after again to be jarred and stretched apart so as to cause renewed and increased torture. The patients become more or less awkward in their gait, watch their footing more, in order to avoid rough or uneven places (cobble-stone pavements, ruts, obstacles), feel less secure on their feet, use their heels more than their toes, and wear away the inner side of the sole of the shoe.

"When the deformity has become evident, the gait and station may change to an actual wobbling, limping, or staggering, and slight efforts of the pedal extremities may require such an excess expenditure of energy and force as to tempt the patient to remain inactive, or at least to save locomotion. As above mentioned, the pains usually are not so severe in this stage, being replaced by a transient dull ache.

"In many, in fact, at least forty-five per cent. of these cases, there is not only localization of painful sensations in the lower parts, but even a high degree of radiation, as above described, so that one may infer a spreading of pain by way of the branches of the sacral and lumbar plexuses, which would perhaps account for symptoms felt in the regions of these cord levels.

"The ages of the individuals examined varied between sixteen and sixty-four years; the majority were in the second and third decade. The duration of the trouble, counting from the time of the beginning of pains in the feet and legs, was from one month to ten years, eighty-three per cent. of the cases being of the acute or sub-acute form."

The following figures quoted from an article read by Royal Whitman, of New York, before the American Orthopedic Association and subsequently published in the *Medical Record*, show that weak feet and flat feet are found in all periods of life:

STATISTICS OF 1,072 CONSECUTIVE CASES OF WEAK FOOT TREATED AT THE HOSPITAL FOR RUPTURED AND CRIPPLED.

Total number of Male Cases, 524.

To 10 yrs. inclusive,	10 to 20 inclusive,	20 to 30 inclusive,	30 to 40 inclusive,	40 to 50 inclusive,	Over 50 years,
68	120	130	108	66	32

Total number of Female Cases, 548.

To 10 yrs. inclusive,	10 to 20 inclusive,	20 to 30 inclusive,	30 to 40 inclusive,	40 to 50 inclusive,	Over 50 years,
39	135	121	120	79	54

Total number of Cases, 1,072.

To 10 yrs. inclusive,	10 to 20 inclusive,	20 to 30 inclusive,	30 to 40 inclusive,	40 to 50 inclusive,	Over 50 years,
107	255	251	228	145	86
9.9%	23.7%	23.4%	21.2%	12.5%	7%

STATISTICS OF 400 CASES FROM PRIVATE PRACTICE.

Total number of Male Cases, 189.

To 10 yrs. inclusive,	10 to 20 inclusive,	20 to 30 inclusive,	30 to 40 inclusive,	40 to 50 inclusive,	Over 50 years,
41	29	37	47	19	16

Total Number of Female Cases, 211.

To 10 yrs. inclusive,	10 to 20 inclusive,	20 to 30 inclusive,	30 to 40 inclusive,	40 to 50 inclusive,	Over 50 years,
27	41	42	46	34	21
68	70	79	93	53	37
17%	17.5%	19.7%	23.2%	13.2%	9.2%

In presenting these figures, Dr. Whitman drew attention to the greater proportionate number of children among the private patients. This is possibly due to the fact that the children of parents able to pay the specialist's fees are more carefully looked after than those among the poorer classes. As to the influence of sex, a growth in weight without a corresponding development of ability to support it, is found most frequently in women whose shoes are most distorted, while in men we see the greater number of cases arising from occupations.

The prevalence of these disabilities is due, I firmly believe, to a failure to recognize their real cause.

Taking flat-foot as an example, we find it attributed to the stretching of ligaments on the bottom of the foot, allowing the bones to

settle down through the breaking of the arch, and on this suggested etiology is based the popular treatment—the wearing of a curved piece of metal in the shoe to hold up the arch.

That the ligaments need not stretch to admit of the production of flat-foot may be shown (1) By the fact that any normal foot can be placed in the position of flat-foot if its owner will relax all leg muscles; (2) by an X-Ray examination of the foot, which will show that although the height of the foot is changed, the relations of the bones of the foot to each other are not changed. Furthermore, a study of the ligaments of the foot will show that they are all cemented together in a common mass, and that there can be no giving way of any of them individually. They are there to bind the bones together, and will break or tear off rather than stretch.

All mal-adjustment of the foot is caused by the lack of balance between the body weight to be supported and the muscle power charged with the maintenance of the equilibrium of the foot under that weight. All deviations of the foot are due to a rolling or rotation of the foot on its long axis, the line drawn from the bony heel to the great toe. Weak-foot and flat-foot, then, is really weak leg, the muscles failing to restore equilibrium after the weight has depressed the inner side of the foot.

This loss of equilibrium may arise from rapid growth in weight, from the general muscle weakness that follows many diseases, especially grippe, or inaction, as, when a person is laid up in bed by an accident, and from overstrain in occupations that cause people to be on their feet for prolonged periods. It is frequently seen in quite young children, and I am inclined to think that in many instances it is a case of infantile paralysis in a very attentuated form. A contributing cause is the faulty footwear commonly worn, which is built without reference to the anatomy of the feet, which forces the foot to remain a crooked axis in the shoe, and consequently diminishes proper foot motion, and which, while providing support on the outside of the foot, where nature has already provided bony support, leaves the weaker side without a firm base, so that the muscles are constantly strained to prevent the foot from overriding the inner border of the heel and shank.

The whole problem is largely one of mechanics; it is a question of center of gravity, or weight and support. Hence, from deviations of the foot, we get bow legs, curved spines and unequal shoulders. If the foundation of the building is not level, the whole structure is out of plumb.

Sufferers from flat-foot and weak-foot should be instructed (1) to provide themselves with rational shoes, shoes which shall be as large as the feet that will wear them, which will present to the ground a surface as large as the bottom of the foot, in which the axis shall be that of the foot, and in which the heel shall be large enough and so placed as to receive the weight of the body as it is transmitted to the foot through the tibia; (2) to avoid toeing out in walking, and cultivate the necessary muscular power to support the

body weight by appropriate exercises. The exercises suggested by Dr. Whitman in his article already referred to are among the best. In brief, they are as follows: In the sitting posture, the feet should always be crossed, so that they rest upon their outer borders, and the weight crowds the top of the foot to the outside. To strengthen the adductors, the limb should be extended, the foot first plantar-flexed, then adducted, inverted, and finally dorsiflexed. The best exercise brings the body weight into play. The patient stands erect, markedly toeing in, with the weight thrown on the outer borders of the feet. The body is then raised on tiptoe, while the legs are kept straight with no bending at the knee. The body then slowly sinks down while the feet are gradually inverted until the weight is supported on the outer borders of the feet as they meet the ground.

And mechanics enters largely, too, into the production of the more serious deformities, of the various types of talipes.

I am glad to see a tendency on the part of a few orthopedists to recognize the fact that the body weight is the greatest factor in producing these deformities, and that they are not due to a vicious contraction of muscles drawing the foot inward. Dividing these wicked muscles or attempted opposition to them by the powerful leverage of a brace accomplishes little. If the divided tendon is not adherent to its surroundings or to its sheath, it must retract to a point where it can no longer perform its functions; if it is adherent to its sheath or its surroundings, there will follow a deposit of plastic lymph that will increase the surrounding adhesions and may reunite the divided ends. The brace has long ago shown its inability to do anything better than act as a crutch which substitutes for muscular action and consequently retards growth and vitality. The brace maker has a lifelong contract with his customer, unless a rival offers some modification of the apparatus that promises a little less discomfort. And in our schools is many a child who is trying to acquire an education in spite of the drawback of the wearing of a brace which is constantly sapping vitality. And public money is spent for hospitals and other institutions for the crippled.

Why do we not recognize that the initial departure in all these deformities is slight, but that the deviation is gradually increased when the extremity is brought into service by the force of gravity, by the pressure of the body weight, which gradually crowds the weakened side of the foot toward the floor, overcoming whatever supporting resistance may be left to the muscles?

Recognizing this, we shall see that the rational treatment is the provision of a firm base for the foot which will not permit it to deviate under the action of gravity; while, at the same time, whatever muscular power may be left in the limb is exercised, so that all the improvement that is possible,—and it is often surprising in amount—is attained.

The correction of these deformities and lesser deviations lies within the power of every physician, and the people themselves can be instructed as to their cause and shown the remedy. This will

be a great gain to the public in the removal of the discomforts and disabilities that now militate against effective work in many channels, and in the deviation of the money now spent for hospitals, for cripples, and for apparatus, into more profitable channels.

DISCUSSION.

SIDNEY F. WILCOX: In discussing Doctor Cole's paper, I must state my belief in the efficacy of any appliance which relieves muscular strain. In one or two articles written in the past, I have discussed this point, and I cannot see why *foot-strain* may not be just as productive of *nerve wear* and *nerve exhaustion*, as eye strain or any other form of constant nervous irritation. But the following must be borne in mind: Properly-adjusted shoes help to maintain the equilibrium and relieve pain, but they do not cure the muscular trouble. One might as well expect to make a lazy or lame horse go faster by pushing on the reins. It may be a relief to the horse not to have the reins pulled upon, but pushing on them does not accelerate his speed. The plea is made for leveling the feet, or rather leveling whatever the feet tread upon; in this case the bottom of the shoe. That is good so far as it goes. The depressed arch may be lifted by supporting apparatus, but it must be remembered that the human foot—and in fact, every other foot—is constructed to walk on irregular surfaces. That is why there are so many bones and joints in it, so that it may accommodate itself to these irregularities. Thus, it is that unless one can always walk on a level surface, the action of the support is always changing. Every sidewalk slopes. If one walks on one side of the street, the axis of the foot is in one direction. If he walks on the other side of the street the axis will incline to the opposite; and so it is all the time, with the irregular surfaces which one is compelled to tread upon in walking. Thus, the individual must constantly be inclining the axis of his body in one direction or the other to maintain his equilibrium. As stated before, I believe the properly-made shoes help in so far as they relieve strain and give support and comfort. They aid in the cure in so far as they relieve the patient of *nerve wear*, but the actual cure must come from the application of therapeutic measures to the muscles themselves. Such are massage, both manual and mechanical, electricity properly applied, and above all, such measures as tend to build up the general health.

HARLAN P. COLE: I am in perfect accord with all stated by Dr. Wilcox in his discussion of my paper, but the point I wish to make is that all efforts at up-building of muscle by massage (manual and mechanical) and electricity properly applied, are almost entirely fruitless, unless the position of the extremity during use has been first corrected, for until correction is established, the various efforts at up-building cannot be assisted or carried out by the patient.

REPORT

OF THE

BUREAU OF NEUROLOGY.

"General Paresis and the Family Physician," - - ROBERT C. WOODMAN.
"Two Cases of General Paresis of Long Duration," - ROY E. MITCHELL.
"The General Practitioner and His Insane Patients," - - REEVE TURNER.
"Homœopathic Treatment of Insanity," - - WILLIAM MORRIS BUTLER.

GENERAL PARESIS AND THE FAMILY PHYSICIAN.

ROBERT C. WOODMAN, M. D.,
MIDDLETOWN, N. Y.

Not long ago a prominent and successful physician told me that he thought that he would not have recognized an ordinary case of general paresis until recently, and that now since his attention has been strongly directed to the subject, he feels sure that he has cared for cases in years gone by without knowing what they were. Our hospital experience seems to indicate that the position of this man is that of a very large proportion of the profession who seem to think that paresis is a subject of no importance to them.

To illustrate: A man of 32 is brought to the hospital by his sister and by their family physician, who had recognized that the man's mind was not sound, and who with another physician had made out commitment papers. In these papers it was noted that the patient was tottering and fell down easily; that he was very weak mentally, said that he was 142 years old, and, though a bookkeeper, he could not correctly count a few cents, nor make simple change. He smiled childishly and wanted to give his money away. When we saw him we noted also that his pupils were unequal and did not react to light. All of his movements were tremulous and inco-ordinate. The tremor was especially marked when he tried to whistle or to show his teeth. His writing was illegible, his speech sputtering and slurred, and he could scarcely walk.

The doctors who had examined him had given a rosy account of what a few weeks in the country would do for him, his sister who accompanied him was buoyed up with hope; and one had to make but the most superficial examination to see that he was far advanced in general paresis, and that this case was an utterly hopeless one.

Our problem, then, was to tell the real state of affairs and to save the reputation of the family doctor, the best we can do; the family that has trusted to his skill and knowledge cannot fail to see that they were lacking.

To be sure, in advanced cases the doctor sees that something serious is the matter, but probably the majority of our cases of paresis were not recognized as such by the family physician. Paresis is not even thought of nor looked for, and that is the reason it is not found. Now, it is not very surprising that graduates of a few years ago do not look for it, for I cannot remember that when I was in college a single word was said about it in any lecture, and I only learned, rather by chance, that there was such a disease through reading about it in the section on Nervous Diseases in a text-book of general medicine. It is because of this general neglect of the subject that I take the liberty to bring it up in this way, and at this time and place; for while it is true that cases will not occur very often in any one man's practice, yet practitioners, especially in large cities where paresis is most prevalent, should inform themselves of its features, both for their own protection and the protection of their clients. Being, as it is, a disease of vigorous manhood; universally fatal; and usually only after a lingering decline; accompanied by so much delusion and mental failure, such cases assume an importance exceeding their absolute numbers.

Satisfactory accounts of the symptoms are to be found both in the text-books for mental and for nervous diseases. I will not weary you with their repetition.

One other phase of the paresis problem especially concerns the general practitioner, and that is its relation to syphilis. I have previously reported a series of cases of paresis in which fifty-seven per cent. had either a syphilitic history or satisfactory physical signs of its occurrence, and there were reasons to believe that many, and possibly all of those remaining might have had it. Higher percentages have been reported, and we may be sure that clinical histories must fail many times to elicit the fact of specific infection; so without being able to say positively just what is the relation between syphilis and paresis, we can say that they are very closely associated clinically. This liability to paresis, after syphilis, seems to us a very important matter, though it is commonly left out of the doctor's consideration in treating syphilis, and in his warnings against the risks of infection. That this is no idle fear, is shown by 567 admissions for paresis in the New York State Hospitals last year, with 414 deaths. Each is a death in what should be the prime of life and usefulness.

DISCUSSION.

REEVE TURNER: I can only echo what Dr. Woodman has told you in his interesting paper. General paresis of the insane is becom-

ing better known as time goes on; and yet we frequently meet physicians who know very little of the symptomatology of this disease, and in fact, who know little above the subject of psychiatry in general. In this, as in other branches of medicine, a little knowledge is a dangerous thing. The tendency is, in treating mental cases, to advise recreation at will, in the form of travel and other nerve and brain-wearing treatments. A little knowledge will mislead one. An examiner in lunacy said of a certain patient that he had every form of mental disease except idiocy.

I have heard of some doctors who, for reasons of temperament, or perhaps dislike of the subject, have had no desire to obtain an understanding of this branch of medicine. One doctor entered a hospital for the insane, but only stayed a few months, as he could not stand the environment. He is a successful general practitioner.

Beginning cases of general paresis are easily mistaken for neurasthenia, or a mild depression or exhaltation, and may be sent to the country to rest, with a prognosis of a quick and permanent recovery. The prognosis seems to have been well founded, for the patient often comes home, to resume work apparently perfectly well. A recurrence of the trouble comes with probably additional symptoms, or a completely new group of symptoms. He may go on this way with remissions, but the tendency is always downward, and death is an inevitable sequel of the process. It is well in all cases of insanity to make a very guarded prognosis. Alcoholic and syphilitic cases sometimes are mistaken for general paresis. In fact, the word "paresis" is used often indiscriminately for almost every form of psychosis, especially for dementia terminal.

As to the syphilitic causation of general paresis: Like locomotor ataxia, there has been great discussion as to whether syphilis is back of every case. I think we will never know positively; but from the experience of physicians who have seen many cases of both diseases, it would seem to be a safe assumption that syphilis is, every time, if we could only find it, a part of each patient's life history. I recently examined a case who presented practically all the symptoms of general paresis, but who showed no physical signs of a previous syphilis. On questioning him as to previous diseases, he mentioned an attack of what he called "itch," "Sacramento itch," I think he called it. On asking him further about the symptoms of this disease, it proved to have been syphilis; the name he gave it being the local term for the disease in that part of California.

In conclusion, I want to say that cases of general paresis are really dangerous ones to be at large, and although after having grandiose delusions, are also frequently paranoid, and liable to injure others.

WILLIAM M. BUTLER: When I left Middletown Asylum several years ago, I thought it was the easiest thing in the world to diagnosticate paresis. All the cases I had seen up to that time were cases that had been brought to the institution fully developed—the maniacal form of paresis. Well, paresis with delusions of grandeur

furnishes only a portion of the cases that are included with that disease. There is the dementive form and the depressed form, and it has been claimed by a good many writers that paresis is changing its type, from the fact that we find often, in cases where they have delusions of grandeur, that they are not so extravagant as they formerly were. In most of the cases we used to see years ago, if a man was rich he had billions of dollars. Now, you will run across a good many cases having the physical symptoms of paresis, yet not having these extensive delusions of grandeur. They will have delusions of grandeur, but they will not be so extravagant. I think one of the most difficult things in the world to diagnosticate is paresis, and the most difficult part is that which falls on the general practitioner. When a case is committed to a lunatic asylum the disease is well developed, so that any tyro who knows anything about paresis ought to be able to diagnosticate it; but when you take a case in the prodromal stage, where the neurasthenic symptoms are predominant, it is an exceedingly difficult disease to diagnosticate, but if you pay attention to the physical symptoms, the condition of the eye, the condition of the muscles of the face and the speech, you are not apt to be deceived. It is claimed by Kraeplin that less than a quarter of the cases of paresis are of the megalomaniacal or expansive form; that two-fifths are of the dementive form, and more than one-quarter of the depressed form. There are many cases that are depressed and have the physical symptoms of paresis, and develop the disease later. This proportion is not borne out by every one. There is a very interesting article in the September number of the *New York Journal of Mental and Nervous Diseases*, by Dr. Pierce Clark and Dr. Atwood. They have examined 3,000 cases that have been in the Islip institution and the Manhattan Hospital for the Insane during the last thirty years, and they have found from this examination seventy per cent. of the megalomaniacal or expansive form, twenty per cent. of the dementive and ten per cent. of the depressed form. But there are few symptoms, to my mind, that have enabled me in those cases in the prodromal stage to make a diagnosis, and there are one or two that I have not seen spoken of very much in the books. One of these is a stiffness of the upper lip. Of course, there is very apt to be a lack of co-ordination in the speech, and you notice, if you look closely at the patient that the upper lip has less movement than is natural. As the disease goes on further, they show a lack of co-ordination in most of the muscles of the face, and the hesitancy of speech is very likely to occur in the first part; that is, in the midst of a sentence they will either stop, or will leave out parts of a word, or will duplicate sentences, or transpose syllables in a word. There is also the condition of the eyes, which in the early stage is not so prominent as in the after stage, yet they are very likely to have at some time of the day some change in the pupil. The pupil may be either too large, unequal or contracted. You are likely to find some one of these symptoms; and it is strange how few of these symptoms a

man may have in the first stage, and yet suddenly have the disease come on in its full force.

I remember a few years ago having a case that came to me with a very slight delusion of grandeur; simply, the man had gone into several businesses, having left his regular business and taken on three or four other businesses; yet he conducted them in a way with which you could really find no fault. One thing he had gone into was the bicycle business; that was at the time when bicycles were such a rage, and being a butcher, that would look a little out of the ordinary; and he also had gone into the tobacco business. This man had this stiffness of the upper lip, and the pupils would change occasionally. But I began to doubt somewhat whether I had not made a mistake in diagnosis, and all at once this man was taken with convulsions, and he had convulsions almost continuously for forty-eight hours, coming out with a fully developed paresis. I guarantee that ninety-nine doctors in a hundred in general practice would not have known what to do—I am sure I would not have if I had not been studying paresis for a long time—from simply this little difference in the action of the muscles of the face and occasional slight changes in the pupil.

Another thing in regard to the family physician in paresis—it makes a great difference which form of the disease you have. If you have a megalomaniacal case, that must be sent to an institution right away, if you are not going to have the family get into trouble; but some depressed and dementive forms can be kept at home longer than they otherwise would be.

But those are the conditions that any man is liable to run into at any time. There are any number of cases that I could recall which have been supposed to be simple neurasthenia, when they were really in the prodromal stage of paresis. Of course, you cannot do anything so far as curing a case of paresis is concerned. There may be a remission for years, even for thirty years.

JOHN E. WILSON: I would like to say just one word, because it is just what Dr. Butler would have said when he was cut off in his prime. I am sorry that he has reversed that old proverb, "Keep a stiff upper lip and trust in the Lord, and you'll get through." It means you'll get in the asylum. The fact is, I think, that there is one cardinal point to be brought out in relation to the whole thing —don't know anything about a patient until you have grounds for knowing something. In carrying that out I would say, do not consider that a person has a psychosis or an organic disease until you have made an examination of that person to the fullest extent that you are able to, and have then some physical data on which to go. That is echoed back and forth in every branch of medicine, and in none is it more notable than in paresis, for in paresis you have a psychosis with some physical changes by which to identify it. Now, you cannot expect to be as expert as a man like Dr. Woodman or Dr. Butler, who have studied the subject for years, but if you find

a man whom you suspect of having some mental trouble, it seems to me that you can make a pretty good shot at paresis if you strip that person and find that there is a lost knee-jerk; if you examine the eyes and find that the pupil is irregular in position, and that it is not only stiff, but that it won't react to light; and if you find in some part of that person's body an insensitiveness to pain and generally some insensitiveness to ordinary touch; if you find these present in the patient, you may say, "Has he tabes dorsalis, or has he paresis?" I think generally you will not be in fault if you find that a person with knee-jerk gone, with pupilary symptoms and some anæsthesias, who is not quite up to the ordinary brightness, perhaps may be anæmic and shows just a form of mental lack that an anæmic person will show, you may be pretty sure that that person has locomotor ataxia or something like it. At any rate, he has not paresis, unless he has shown some change of disposition which is irritability or which is in the line that the Doctor has mentioned.

TWO CASES OF GENERAL PARESIS OF LONG DURATION.

R. E. MITCHELL, M. D.,
MIDDLETOWN, N. Y.

A case of general paresis with a clinical course of ten years is unusual, and cases of over twenty years' duration are so rare that few have been reported. Two such cases have been observed at the Middletown State Hospital, the only cases out of about four hundred to live more than ten years.

Case 1. H. R., No. 4070, admitted February 15, 1894. A Jewish police officer, married, aged 35. Three years before he had been thrown to the ground and his head hurt by a prisoner (no details but supposedly made a good recovery); insanity in the family denied.

For six weeks he had been acting strangely, had extravagant ideas of wealth, said the police were persecuting him. On admission he talked excitedly of his record as an officer, his ability and strength, his great wealth. Said he was chief of police in New York (in reality a patrolman), and that his baby, four months old, could speak four languages while he himself was master of twenty-four. Physically, he was in good condition. The right pupil was larger than the left, and remained so. Venereal disease was denied, but he had a deep scar on the glands.

He changed little in 1894 except that by November the pupilary reaction to light was sluggish and late in that month he had an apoplectic seizure. Immediately following this seizure he was

unconscious for a few minutes, was dull the remainder of the day, and for several days thereafter he was restless, fault-finding and destructive. In April, 1895, he was not so strong physically, and seemed duller, talked disconnectedly of his money, horses, etc. In July, 1895, he had a second apoplectic seizure while at dinner, and recovered quickly. In 1896, both physical and mental failure became more pronounced. He grew very irritable, attacked the nurses and other patients without cause. He was restless at night, slept irregularly, talked to himself. He continued untidy and destructive. In 1897 all these traits were more pronounced; he was very filthy, persisted in throwing food from the windows because he thought it poisoned. In 1898 he had reached the bed-treatment stage, was more feeble from then on and had incontinence of urine. His mood varied; at times pleasant, again exceedingly irritable, usually loud-talking, profane and obscene. In 1899 he was able to articulate fairly well, and seemed stronger for a time. After a fainting attack in 1900 he grew more deteriorated. In 1901 he is noted as being most untidy and destructive of bedding and clothing. In 1902 he gained in weight and grew so much stronger that he was able to walk with assistance. In 1903 he was more destructive, would tear a garment to pieces and tie the pieces in knots; was prone to throw things into the water closet. There was practically no change in 1904 until November 5th, when he choked while being fed his supper of bread and milk. He died within a few minutes, in spite of efforts to relieve him. At the autopsy a plug of bread was found, wedged fairly tightly at the bifurcation of the trachea. Here, an accidental death terminated a clinical course of *ten years and ten months.*

Dr. Meyer, director of the Pathological Institute (New York State Hospitals), kindly furnished a report of the pathological conditions found in the brain. The brain was of good size (forty-five ounces). The pia showed moderate thickening and some opaque spots, especially in the frontal region, and considerable œdema over the convexity. Rather firm adhesions between the frontal lobes. Frontal convolutions narrow. Fine granulations in the fourth ventricle. Vessels rather prominent, but not sclerotic. Sections showed a slight but general infiltration of the pia and cortical vessels, with lymphoid and plasma cells. There was a moderate congestion of all the viscera and the larger arteries were filled with fluid blood. No arteriosclerosis (gross examination).

Case 2. M. O. First admitted September 9, 1884; number 1536. An American woman of 37, single, housekeeper, good habits. No venereal history; insanity in the family denied. For ten days she had been moving about almost constantly. Her conduct was immodest; swearing, kicking and striking. Staring expression.

Upon admission she was found much reduced physically, rapid weak pulse, pupils widely dilated, numerous bruises. She threw herself from side to side, gave scant attention to questions, talked

incoherently most of the time. Was so restless that proper care was rendered difficult.

At first she was thought to be a case of acute delirious mania; subsequently a diagnosis of general paresis was made.

During 1884 the general physical condition improved slightly, but the pupils did not react to light, and the lips were tremulous. She became very destructive and when mitts were placed on her she regarded them as babies and talked affectionately to them. Much of her talk was incoherent, but at times she was quite sensible. She claimed to be able to make $5,000 a day at her receptions, pointed out ships, horses and trains of cars that she saw in the air. She displayed considerable sexual excitement, and developed the idea that she was married. Her language was apt to be profane and obscene, and her mood varied. Later, she realized that she had said some improbable things and wondered why she had made such statements. A poor memory was established. In 1885 she continued to grow stronger, was dressed and about and later did some work. She was better-natured, but still displayed much sexual excitement, and carried on open flirtations when the opportunity offered. The physical signs were marked (speech defect, sluggish pupils, fibrillary twitching and drooping of the left lid). Her family took her home where she got along quite satisfactorily, although she was not considered well.

She was re-admitted January 31, 1887, after having remained at home nearly two years. For three months she had gradually grown worse, could not care for herself, showed little sense of modesty. Vacant facial expression, low muttering speech.

On admission she was found to be weak, arms and legs tremulous, numerous bruises on the body. The left pupil was contracted, the right widely dilated, and the right eye turned outward. Involuntary stool and urine. The patient herself was dull, and paid little attention to questions, although she answered some in an indifferent way.

This time no one questioned the diagnosis of general paresis.

In 1887 the neurological picture varied; in February a transient, left-sided facial paralysis; in March and April a left-sided ptosis; in December a paralysis of the right side of the head and left side of the body. The pupils were dilated and sluggish, speech defect became very pronounced, persistent twitching of the lips and general tremor. She gradually grew so weak and unsteady that she was bedridden, and finally was not able to feed herself. Early in the year she talked expansively of her money and jewels (said she owned tubs full of diamonds, gave imaginary ones away by the handful, told about her rich gold mine, etc.). She talked, sang and laughed a good deal, explaining that she was bringing the dead back to life. She continued somewhat restless, irritable and resistive until late in the year, when she grew very dull and paid little attention to anything. She would open her eyes when spoken to loudly, but she did not answer nor did her facial expression change. She

was a little stronger in 1888, but some jerking of the muscles of the forearms and hands was noticed. With the physical improvement she was ugly and hard to care for. She said she was 16 years old, weighed five pounds, and was kept here for her diamonds. In January, 1889, she lost free use of her legs; they were not strong afterward. Shortly after there was a paralysis of the left side of the body, quickly followed by a right-sided paralysis, which also cleared up rapidly, and again the left-sided condition appeared (all came and went in the course of a few days). Her delusions became more extravagant; she owned everything; the rugs on the floor of her room cost fifty millions apiece; two men lived inside her; her hands talked to her. In 1890, she was strong enough to sit up at times, called herself the Queen of London, later said she was the Queen of France. From that time there was little change in her condition, until shortly before she died. Most of the time she was an untidy bed patient, at times she sat up, and once in a while she walked a little (with assistance). As a rule, she was able to feed herself. She exposed herself carelessly, and called attention to her "beautiful" body. She was almost always cross, and resisted being cared for. At times she screamed and scolded at imaginary persons. She was always profane, and heaped abuse and obscenity upon the nurses. Intelligible words became fewer and fewer, until for two years preceding death a few profane remarks were all that were left. Deterioration seemed to have reached the extreme limit. In 1905 an examination of the cerebro spinal fluid showed a definite lymphocytosis. In 1906 she lost steadily in weight, and contractures became well marked (the legs were drawn up and the thighs rotated to the right, the right arm was held semi-rigid to the side, and the fingers were sharply flexed; later the fingers of the left hand became moderately flexed). In November a number of bed sores appeared. On December 2d she had a slight convulsion, followed by stupor for one day. In this seizure the head and eyes were turned to the left, there was twitching at the right angle of the mouth, and the pupils were widely dilated and rigid. She gradually improved, and on December 14th was apparently the same as before the seizure, except that she did not speak again until the 24th. A cystitis developed, and after several days of low fever, some difficulty in breathing (but no cough) and a moderate increase in the pulse rate. She died on January 7, 1907, *twenty-two years and four months after the onset of the disease.*

The brain was of fair size (40 ounces). Cortical atrophy was most marked, especially in the frontal region, and to a less extent in the parietal region, giving the forebrain an odd, wedge-shaped appearance. The pia-arachnoid was very œdematous, the frontal lobes were adherent to each other, there were large granulations in the fourth ventricle. The dura was quite adherent to the pia, and presented a relatively large area of hemorrhagic pacchymeningitis in the left temporal fossa. The larger vessels (the basilar and carotids) showed a rather diffuse sclerosis, while calcareous patches were

observed along the course of the Sylvian branches. The cord was small, with milky pia and thick dura. Sections of the cortex and cord confirmed the gross findings of paresis; a scanty plasma cell infiltration of the pia and the cortical vessels was found. In addition, a fairly well-marked wasting (due to the sclerotic vessels) was observed. The cord showed a decided wasting of the posterior columns. All the organs showed well marked sclerotic changes, the lungs a catarrhal pneumonia and the bladder an ulcerative cystitis.

In conclusion: Each of these cases presented quite typical clinical symptoms of paresis. The gross anatomical findings were almost classical and the finding of a general, although scanty, plasma cell infiltration of the cortex furnished definite confirmatory proof.

The second (long) case had a fairly well-defined remission early in the course of the disease. The long periods of relative inactivity of the disease process later on, when deterioration had become pronounced, were probably of a similar nature.

The prolonged course, in each instance, may suggest to some a possible successful method of treating paresis. A review of the general and remedial treatment of these cases, while differing slightly from that of any other individual case, does not present any definite or unusual features. Exact figures as to the duration of paresis are hard to get. Several years ago, Dr. Woodman went over all the Middletown cases and found that the general average was about three years. I consider this a conservative figure, and I believe that it compares favorably with that of any other institution. Why these particular cases lived so much longer than the average case, I do not know; I have no theory to offer. It is possible that early bed treatment had something to do with it, but if so, why did not this same factor bring about a different result in the large number of cases that died after a few years' care? A final analysis is disappointing, for, while they lived a long time, they practically vegetated after the time that death usually occurs.

DISCUSSION.

JOHN T. GREENLEAF: The discussion of a paper of this kind would demand of me only to add my own experience to what has been stated. Of course, you know that in a case of general paresis which has been presented to you there are three questions you are asked to answer. First, you are required to give your diagnosis. You say it is general paresis. That makes your answer. The next is, What can you do for it? Nothing. The third is, How long will this poor man go on before he dies? Three years. That is the rule that we have been following for a good many years. Of course, a case like this that the Doctor gives us, a case like one of my own, that went six years, with a remission of a year and a half; one of

four years, with a remission of six months; one of nearly seven years, with a remission of two years; in each of those cases the men going back to their business and carrying it on successfully for six months, for a year and a half and for two years—cases of that kind prove to us that the revision which is now taking place in the diagnosis, in the symptomatology, of cases of mental trouble, is very much needed. And yet when you come to consider that the care of an insane person as a sick person is not more than eighty years, or eighty-five years old, since Hahnemann said that these people were not possessed of the devil—although a good many of us who take care of them think they are—they were not those who should be chained down or shut up and fed twice a day through the window of a little hovel, as you would pass food to a dog, but that these people were sick and required medicine. That was Hahnemann's position. When you come to consider that it is only eighty or eighty-five years since that was set forth, I think we have done pretty well. I think we have a pretty clear idea of mental disease.

I think we ought to notice right here that in cases of this kind, cases of general paresis, the diagnosis is difficult, as Dr. Butler says; and that any practitioner who will take pains to wait a little, not give his diagnosis the first day, for that cannot always be done; wait until he has examined the case again, and wait a little until the matter clears itself up, even though these patients put on a certain amount of self-control and appear a great deal better before you than they are; wait a little. This will clear up. Then when the diagnosis is gotten and you know where you are, you know what to do; and you know, as the Doctor has said, that these people ought to be shut up, or they do damage to themselves or someone else.

I am very glad to have had the opportunity to say a few words in regard to the paper, and I know that general paresis will appear to you in a more definite form than heretofore.

MAURICE C. ASHLEY: I would like to add a word concerning general paresis. Dr. Greenleaf brings out a point that is often misleading to the general practitioner—the fact that a case of paresis may have a remission. The general practitioner frequently makes a mistake in believing that he has made a wrong diagnosis when he diagnosed paresis, when it is followed by a remission. That he should avoid as far as possible.

One thing in connection with paresis, as well as several other forms of mental disease, which comes to me personally in rather an acute way, and sometimes very painful, is the present law which permits physicians to send to the Middletown or the Gowanda State Hospital, patients from any part of the State who may wish Homeopathic treatment; and I want to say in this connection that it seems unwise, in cases of general paresis in the last stages, to send patients from Rochester, or Buffalo, or St. Lawrence County to Middletown or Gowanda to die. That is all that can be expected

in a case of general paresis. It was only a few days ago that a bed-ridden case of general paresis in the very last stages, was received from St. Lawrence County, sent down by a homeopathic physician, to have homeopathic treatment.

THE GENERAL PRACTITIONER AND HIS INSANE PATIENTS.

REEVE TURNER, M. D.,
NEW YORK CITY.

" But see the madman rage downright
With furious looks, a ghastly sight.
Naked in chains bound doth he lie,
And roars amain he knows not why!
Observe him; for as in a glass,
Thine angry portraiture it was.
His picture keep still in thy presence;
'Twixt him and thee, there's no difference."

This description of a "Maniac," taken from Burton's Anatomy of Melancholy, might well have been descriptive of similar cases up to comparatively recent times.

Pinel, in France and the Quakers, in England, were the first to do away with chains; but reform came slowly. Only a short time ago mechanical restraint, in the form of jackets, cribs, leather hand-cuffs and straps, was considered necessary for the proper care and treatment of those mentally sick.

All this is changed, in New York State, at least, and it is now known that the necessity for restraint of this kind never existed. Nor have sedatives taken its place. True, it has been found necessary to increase the number of nurses; but what of that, if the fear and horror created in many patients' minds by the contemplation of ties and straps, chloroform and mufflers can be done away with forever?

It must not be forgotten, however, that although the old system of mechanical restraint caused grave abuses, the majority of the physicians who used it had in mind the best interests of the sick ones.

Wherever the nursing force is inadequate, mechanical restraint or sedatives become necessary.

You may ask, what has this to do with the general practitioner? Doctor, do you know that the average individual still harbors the "padded cell," "strait-jacket" idea of the so-called "insane asylum?"

Tell your patients, friends and relatives of patients, that there are

attractive parlors and halls, clean hospital wards with white beds in orderly rows, and often more quiet found there than can be found in many wards in general hospitals.

Those sightseers who go through a State hospital expecting "thrills," are apt to be disappointed. There is less chance for such experiences than on the streets of a crowded city.

Tell those who are interested that the old idea of a "mad house," with all its terrors, is certainly a thing of the past.

Most people have no knowledge of the modern method of treating the insane; they have an almost instinctive repugnance for anything pertaining to insanity and the insane. It is your duty, doctor, to instruct them and to give them a sensible idea of the subject.

Sometimes the relatives will have sufficient reasons for wishing the case treated at home, or you may think it advisable. The problem will then be to organize a hospital system in a private house; to have sufficient nurses—often day and night—and to have strict seclusion for the patient.

You will not often have this condition to face, perhaps. Money may be so limited in amount that removal to a State hospital or other institution is absolutely necessary.

Then it is that the careful physician must know the ground on which he treads. Before sending your patients to such a place, inspect it carefully.

Always remember that whether at home or in institutions, there should be provided sufficient nurses for the proper care of the patient. This can be done without incurring the cost of special nurses. Make your strength felt and insist on having what is right. In that way you will have your share in the progress that is being made.

Accidents will happen, even in hospitals where nurses, both night and day, are many and capable; and all possible precautions are taken to avoid disasters.

Outside of institutions, where little or no care is exercised to guard and protect the insane, homicides and suicides are common occurrences.

The number of these can be, and should be, greatly reduced if the mental states of the individuals are appreciated, and some steps taken to keep the sufferers under the watchful care of persons capable and experienced in the rational methods of dealing with the insane. The general practitioner can explain to the families having such cases the dangers they are daily running. How often we read of a suicide or homicide, who had been evincing signs of mental derangement for some time. Only yesterday a man "who had been noticed as acting peculiarly for a long time," took his two-year-old daughter to the river, and threw her in as an offering to God. That life could have been spared had the father's mental condition been correctly judged and proper precautions taken. Now, no doubt, he will be given care.

When recommending supervision or care for a patient, and when

warning the relatives of possible suicidal or homicidal tendencies, you may be greeted with something like the following: "Oh, no, Doctor, you must be mistaken; he wouldn't do such a thing. He was always such a cheerful man, and loved his family so much." One should not listen to the relatives to the exclusion of the promptings of one's best judgment as to the advisability or not of sending the patient to a hospital.

You will sometimes hear this: "Doctor, if we should send him to a hospital it would just kill him. He never could bear the sight of misery." Listen respectfully to all this; give your advice, and if they refuse to follow it, retire from the case. You would do it in other diseases, do it, then, with your cases of insanity.

Most cases of insanity have blunted or altered powers of perception, so that changes in environment are not noted with the same degree of interest or correctness that they would be in health.

The patient may be in such a mental condition that heaven would appear hell to him, or so elated that he would not find fault with Bedlam madhouse in its worst days.

Some cases lack interest in their surroundings through pre-occupation, retardation or through changes in the brain resulting in dementia.

Always remember, and impress the fact upon those interested in the patient, that there has occurred a distinct change in the patient's mental attitude; and that ideas and opinions held by the patient before sickness overtook him now have been forgotten, altered, or their places taken by different ones, often opposed to the ones formerly expressed by him. The tendency is, too often, to look upon and treat the patient either as a person who has perfect control of himself, or as a naughty child.

Many times the patient has a better appreciation of his mental state than others. Witness the case of a man who insisted on his wife chaining him at night, so that he could not, when his insane fancies prompted him to do so, kill the whole family.

As general practitioners you will have to exert your influence to stop the carelessness exhibited sometimes by those who are caring for mental cases temporarily confined in general hospitals. A case where no precautions were taken is one that occurred in one of the largest hospitals in New York city. A young woman, suffering from a form of depression, was left alone by the night nurse. She took the opportunity to jump out of the window. Through the fact, possibly, that she was being treated as they treat persons of normal mentality, she was not visited by anyone again that night, and was found the following morning lying unconscious in the court below. She recovered her reason in an institution for the care of the insane, but will always bear the marks of that fall.

One often hears and reads of patients, in the delirium of typhoid or other acute diseases, jumping out of hospital windows, many times to be instantly killed. Such accidents can, and should, be guarded against.

Although not suffering from an actual psychosis, these cases are for the time practically insane, and should be so treated.

During such delirium, even though mild, the cases should have the watchful care of a nurse both day and night.

I want to say a few words about the many cases of alcoholism and drug habits. What shall be done with them? They are often actually insane, and are a big burden and source of expense to themselves and others. Many of the most dangerous of alienated cases come from this class. The physician does not care to send them to the so-called "cures," and yet he has little choice.

They usually travel from pillar to post, unless by some act they get within the grasp of the law, when they are promptly taken care of, usually in prison. If they go voluntarily to an institution, there is little restraint. Commitment is attended with risk, as such cases are good subjects for shyster lawyers, with their habeas corpus proceedings.

It is understood that in this State some attempt is being made, or about to be made, to harbor such cases under proper legal restraint in a hospital especially conducted for alcoholics, where they will have all possible opportunity to recover from their habits.

Now for a few "don'ts:"

Don't make your prognoses too hopeful. You are apt to be disappointed.

Don't send your patient out on a globe-trotting expedition. He needs rest, and lots of it. Recreation can come after recovery.

Don't listen too attentively to the relatives' wishes regarding treatment. Usually they know little about insanity.

Don't take the case if you cannot have your way.

Don't treat a case at home, unless you can command sufficient assistance.

Don't trust the patient unless you are absolutely sure; and then, look out!

Don't trust a convalescing patient as much as you would one in the height of an attack. Accidents more often occur when recovery is near than at any other time.

Don't spoil the patient's chances with bromides and other sedatives.

And above all, don't forget that the indicated remedy, homeopathically applied, is the best curative treatment.

DISCUSSION.

JOHN E. WILSON: The discussion of that paper is a good deal like discussing the ten commandments—it is all done. But I did want to say just a word, perhaps putting in different phrase what the essayist has already stated, and that is to impress upon the family, when you are brought in to take care of a case, that common sense does not run in the treatment of insane people. All the

arguments of the family are based on what we call common sense, and that usually is detrimental to the person; and in that connection, and along the same line of thought the Doctor has expressed, in the matter of fatigue, having a person with a tired brain, and usually a very tired body, entertained by relays of friends, does not come within my ideas of curative measures, though it seems to be very popular. The next thing is that I do not believe that a treatment which surrounds a patient with elaborate safeguards and special measures is good for a disease of which egotism is one of the prime marks. I believe they do a great deal better where they are not playing to the gallery; where they are put into an environment which will rest them, which will not excite them and make them the center of the stage; and along with that goes the feeling that as between a private institution—begging your pardon—and a large public institution, where the person is Number So-and-so, instead of a great man in the best room in the house, the public institution is the best for him right straight along.

WM. M. BUTLER: I want to put in just three more "dont's." Don't try to take care of a case of paranoia at home. Don't take care of any suicidal case, unless you can have sufficient nurses that are trained, and not members of the family; and don't try to take care of a case of megalomaniacal paresis.

THE HOMŒOPATHIC TREATMENT OF MENTAL DISEASES.

WILLIAM MORRIS BUTLER, A. M., M. D.,
BROOKLYN, N. Y.

Any form of medical treatment of insanity, to be successful, must be supplemented by suitable diet, physical rest, proper hygienic measures, sanitary surroundings and due regard for the moral environment of the patient. Suicidal and homicidal cases must be kept constantly under the closest surveillance, and every possible effort should be made to turn the mind from its abnormal into normal channels of thought. If these points are disregarded, no remedy, however carefully selected or suitable to the case can achieve success.

The success of Homeopathy in the treatment of insanity depends upon the care taken in the selection of the remedy in each individual case. When called to treat any case of mental disease, the physician should make a careful examination (1) As to the patient's general physical condition; (2) every physical disturbance should be considered and its relation to the mental disease accurately determined;

(3) every variation from the patient's normal state should be ascertained; (4) having noted all the subjective and abjective symptoms presented by the patient, together with those elicited from the general history of the case, the totality of these symptoms should be made the basis of a prescription and the remedy most closely indicated should be selected according to the law of similars.

In entering upon the selection of the drug, try to do so without prejudice for any particular remedy. Do not give belladonna simply because the disease happens to be mania, or ars, because it happens to be melancholia. Let the closeness of the similarity of the symptoms in each individual case be the only guide in the selection of the remedy.

The time allowed us will prevent our considering the treatment of all mental diseases, and we shall therefore consider only melancholia and mania, and give simply the symptoms of those drugs which we have found most often indicated and most frequently curative.

Melancholia.—The remedies which we can most emphatically recommend under this head are, Acon., Actæa Rac., Ars., Bap. Bell., China, Dig., Ign., Lil. Tig., Nat. Mur., Puls., Sepia, Verat., Alb.

Aconite.—Aconite is chiefly useful in melancholia of pregnancy, when the prevailing mental note is fear of death which the patient continually asserts will occur in her approaching parturition, and distresses all about her by ceaseless weeping and lamentations. There is also great restlessness and sleeplessness or sleep disturbed by disagreeable dreams.

Actæa Rac.—Thinks she is becoming insane. Greatly depressed by fear of death and a sensation as if something had settled down upon the brain, rendering everything dark and obscure. Severe pain in the occiput and through the eyes, as if they were penetrated by sharp instruments. Nausea, false labor pains, sleeplessness. Often indicated in the melancholia of pregnancy, when it occurs in hysterical, rheumatic and neuralgic subjects who have suffered much from uterine disorders.

Arsenicum Album.—Arsenicum album is one of the most valuable and frequently indicated remedies in severe cases of acute melancholia and melancholia agitata.

Arsenicum is chiefly effective in the severest type of the disease. Both the physical and mental symptoms reveal at a glance the dangerous character of the malady. The face is pale the features pinched, the countenance anxious, and haggard, the skin shriveled, the pulse rapid, weak and wiry. The tongue is red, dry, parched and tremulous, and the patient is continually tortured by the characteristic arsenicum thirst. Emaciation speedily takes place. Impelled by an overpowering restlessness, if allowed to remain upon their feet, the victims unceasingly pace up and down their apartments night and day, wringing their hands and agonizingly bewail their fate. If in bed, they constantly roll from side to side, incapa-

ble of rest. In their agony they pull out their hair, bite their nails to the quick, and may inflict upon themselves the most serious physical mutilations. Driven to desperation, unless constantly watched, they invariably seek escape from their misery through suicide. Yet these desperate and apparently hopeless cases, if prevented from injuring and killing themselves, and properly nursed and sustained by a sufficient quantity of nourishing food, by the marvelous influence of arsenic, are often restored to perfect health of body and mind.

Baptisia.—Baptisia is especially potent in the severest and most dangerous forms of melancholia with stupor. When this disease assumes a typhoid type, and the temperature is excessively high, the pulse and respiration are extremely rapid, the countenance dark and sodden, the eye devoid of expression, the breath fetid, the tongue dry and brown, the teeth covered with sordes, and frequent offensive involuntary stools are present, you can look with hope to baptisia. Under its influence, this formidable array of symptoms, signs of a virulent toxæmia, often disappear as by magic, and complete mental and physical restoration takes place.

Belladonna.—The belladonna melancholic is exceedingly depressed, fearful, and subject to violent attacks of weeping. The characteristic indications are a general passive cerebral congestion. When this combination appears, belladonna is exceedingly effective, especially if given in the lower potencies.

China.—China is only effective when the disease has resulted from an excessive drain of some of the vital fluids, but in these cases has produced some marvellous results. It should be given in appreciable doses.

Digitalis.—The chief indication of digitalis in melancholia is a slow pulse, attended by a general appearance of exhaustion and debility. It is not as often demanded as some other remedies, but when indicated, exceedingly reliable.

Ignatia.—Ignatia is frequently indicated in acute melancholia when the disease has been produced by shock or prolonged brooding over real or imaginary troubles, and when the relief of tears is denied. These patients are obstinate, resistive, taciturn, and given to brooding. Proffered sympathy is rejected, but if it is not offered they imagine themselves neglected by their friends. In spite of tendency to brooding, they are inclined to be hysterical, and often indulge in senseless laughter. Another infrequent symptom may appear recorded in the Materia Medica as "lasciviousness without erections, sexual desire with impotence, itching around genitals and penis." One patient of melancholia, given to constant masturbation with this group of symptoms, came under my care and was promptly relieved by a high potency of ignatia, after all the ordinary homeopathic antaphrodisiac remedies had failed.

Lilium Tignium.—Depression, tearfulness, timidity, fear of some fatal disease or insanity, weakness of memory and difficulty in the

selection of proper words when conversing. Irritability of the bladder with pressure upon the rectum. Adapted to neuralgic and hysterical women, who have suffered from functional or slight organic disorders of the uterus and ovaries.

Natrum muriaticum.—The natrum muriaticum patient is emaciated, and the face has a prematurely old look. The memory is weak and there is a general mental and physical exhaustion causing a disinclination for any kind of work. These patients shed floods of tears, and the more they are comforted the more violently they weep. Revelling in their grief, these cases derive satisfaction from recalling all the disagreeable occurrences of the past, for the purpose of indulging in melancholy meditation. Ill-humored and taciturn, easily provoked by any contradiction, they avoid companionship, believing that they are pitied by everyone on account of their misfortunes.

Especially indicated when the melancholia has followed intermittent fever and when the outbursts of weeping are periodic in their occurrence.

Pulsatilla.—Melancholia manifested by frequent weeping, solicitude concerning health, despair of salvation, constant praying and great anguish, causing her to desire to commit suicide. Variable moods, at times depressed and tearful, then joyous and happy. Adapted to women of mild, gentle, affectionate dispositions, possessing little vim, pulsatilla is frequently demanded in melancholia of pregnancy when complicated by gastric disorders.

Sepia.—Nervous, irritable, sensitive to the least noise, dread of being alone. Sadness with solicitude about her health and the future. Frequent paroxysms of weeping, aggravated at night and in the open air. Indifference, and aversion to members of her family. Indolence and disinclination for any work. Weakness of memory and difficulty in expressing her ideas. Sleep restless, and filled with disturbing dreams, awakening in a fright. Profuse, yellowish, or white, acrid, exceedingly offensive leucorrhœa. Sepia is chiefly in melancholia which occurs in women as the result of a chronic leucorrhœa and organic disease of the uterus and ovaries.

Veratrum Album.—Sad, despondent, tearful, despairing of salvation. Fearful and apprehensive of misfortune. Dull, stupid, obstinately taciturn. With the mental are usually associated many physical signs of a lowered vitality and marked disturbance of the heart's action.

Especially efficacious in severe forms of melancholia with stupor, characterized by excessive dullness, taciturnity, refusal of food and great physical weakness, shown by the cold, blue, clammy skin, weak and intermittent pulse and occasional fainting spells and temporary loss of consciousness. Under the influence of veratrum album many apparently hopeless cases have been completely restored. Care should be taken lest the drug be too soon discontinued, as these patients are liable to relapse if the cure is not firmly established, but when it is accomplished it usually remains permanent.

Mania.—The drugs most frequently curative in mania are anacardium, belladonna, cantharides, hyoscyamus, phosphorus, stramonium, veratrum album and veratrum viride.

Anacardium.—The anacardium patient is often possessed by the delusion that he is controlled by two antagonistic forces, the one inciting to evil, the other urging him to be good. He is often disoriented as to time and his surroundings. Filled with hallucinations of hearing voices constantly whisper in his ears obscure and blasphemous words.

The anacardium patient is chiefly characterized by his ugliness and frightful profanity. We have found it more often curative in chronic mania than any other remedy, especially if attended by some impairment of memory.

Belladonna.—The belladonna patient, in violent fury, bites, strikes and kicks or tears everything to pieces. The talk is excited and incoherent. The mental condition is ever changing; one moment he may be brave and pugilistic, the next terrified and cringing. Every imaginable hallucination of sight may pass before the eyes—ghosts, hideous faces, animals or instruments of torture. Extremely fickle, with constantly changing mental moods, these patients one moment dance, sing and laugh, the next are seized by most fearful paroxysms of rage and violence.

With the mental are usually associated the ordinary congestive symptoms. No other remedy is as often indicated in acute forms of mania as belladonna.

Cantharides.—Cantharides resembles belladonna in its violent excitement. These patients are exceedingly destructive, and especially inclined to bite at anyone who approaches, or they will bite the sheets and bed clothing. They are restless, moan and groan, and often bark like a dog. They are filled with hallucinations, especially of sight, and frequently converse with people long dead. Like the anacardium patient, they show a strong tendency to swear, and are worse at night. The eyes are bright, pupils widely dilated, face yellow, unlike the red face of belladonna, and wrinkled with a constant frown and expression of extreme suffering. The slightest touch aggravates the symptoms, as does also any dazzling object, like a mirror or a glass of water.

The chief characteristic of cantharides is the intense, almost overpowering sexual excitement, which accompanies the violence, driving the patient to seek immediate sexual gratification; hence, they are usually most desperate and excessive masturbators.

The violence of cantharides is paroxysmal, but terrific while it lasts. This remedy is frequently indicated when the exciting cause of the disease has been masturbation. Associated with this mental group is usually found the characteristic bladder symptoms of cantharides.

Hyoscyamus.—The hyoscyamus is not as violent and dangerous as the belladonna, and is less wild, and more easily controlled than

the stramonium patient. She sings, cries, laughs, scolds, swears, talks obscurely and often accuses herself and her husband of infidelity. A common delusion is that she is being poisoned by her medicine or food, and on this account may not take either voluntarily. The delusions and moods are exceedingly changeable, but the patient is usually jolly and good-natured, but nervous, restless, and sleepless. There is great sexual excitement, with much lascivious talk and constant desire to expose the person and remain naked. Hyoscyamus is especially suitable for young, hysterical, nervous and easily-excited women, and is very often curative in mania.

Phosphorus.—Violent delirium, with restlessness, fear of death and constant desire to escape. Loud screaming, with attempts to bite and strike those about him. Hallucinations of sight, sees faces leering at him wherever he may look. Nervous starting at the slightest noise. Intense sexual desire, with entire shamelessness and constant attempts to remove all clothing and go naked. Irritable, fretful, peevish, fearful; worse towards evening; sleepless before midnight.

Phosphorus is not as frequently demanded as some other drugs, but exceedingly satisfactory when indicated. One of its most reliable symptoms is the presence of hallucinations of sight; "faces peering from every corner." With this symptom we have never failed to relieve the patient by the exhibition of phosphorus. It is most frequently demanded in cases with sexual excitement, and where the disease has arisen from a depleted state of the brain and general nervous system.

Stramonium. While representing by its provings a wide range of mental symptoms, stramonium has achieved its greatest curative triumphs in the severest class of cases. When the delirium is wild and furious, and the patient is possessed by the most fearful delusions, illusions and hallucinations, then is stramonium most clearly indicated, and seldom fails to bring speedy relief. It differs chiefly from belladonna in the greater intensity of the mental excitement.

In acute mania, epileptic insanity, and delirium tremens it is often indicated and frequently curative.

Veratrum Album.—The furious delirium of veratrum album, with violence and destructiveness, resembles that of belladonna and stramonium. In veratrum album, however, we have much greater physical exhaustion, evidenced by a weak pulse, coldness of the body and cold sweat on the forehead. The veratrum patient must have speedy relief or die. Veratrum album is especially efficacious in mania occurring in women, where the disease is dependent upon some disorder of the sexual organs, and is aggravated at each menstrual period, or in women whose menses have been suppressed and who imagine themselves pregnant. Many of these cases are subject to amorous frenzies, which are strangely mixed with the wildest religious vagaries.

Veratrum Viride. Veratrum viride has few mental symptoms

recorded in its provings, but has been found extremely useful in many mental diseases. In acute delirious mania, with a very high temperature and exceedingly rapid pulse and respiration, we have frequently found its effect marvelous.

When, however, it has lowered the temperature and lessened the rapidity of the pulse and respiration its work is done.

DISCUSSION.

JOHN L. MOFFAT: I do not want to discuss insanity, but I want to express the thanks of the Society to Dr. Butler for giving his old-fashioned homeopathic paper, a model for every Bureau—that we can come here and learn Homeopathy.

WM. M. BUTLER: I have often heard it said that in the Homeopathic College we did not teach any homeopathic materia medica. I give them, in the treatment of mental diseases, nothing but this sort of instruction; never give them anything about bromides, or chloral, or outside measures, anything outside of our homeopathic materia medica, because I know if they want that they can get it over at the Physicians and Surgeons better than I can give it. But I calculate, when I drive materia medica at them in this shape, that I am giving them some materia medica.

REPORT

OF THE

BUREAU OF CLINICAL MEDICINE.

"Medical Examining Boards, Past, Present and Future," WILLIAM S. SEARLE.
"Recent Aids in the Diagnosis of Tuberculosis," - - GEO. F. LAIDLAW.

STATE BOARDS OF EXAMINERS IN MEDICINE, THEIR PAST, PRESENT AND FUTURE.

W. S. SEARLE, A. B., M. D.,
BROOKLYN, N. Y.
Vice-President and Examiner in Diagnosis of the New York State Board Under the Law of 1907.

At the earnest request of our President, I have consented to prepare the following paper upon State Boards of Examiners in Medicine in America. I comply with his request first, because it forms a part (and a not unimportant part) of the medical history of our State and nation; next, because, after nearly two decades of experience with the "three-board system," our legislature has determined to try the "single board" plan, which, so far as I can find out, has been successful and, on the whole, satisfactory in other States of our Union.

It appears to me improbable that the present system will be changed in any important particular for a considerable time, and during this interval it may be well to look at the whole matter from an historic standpoint.

I have hesitated to undertake this task because I cannot perform it without appearing, to some of you at least, unpleasantly egotistical. I have long served, mainly in the ranks, of this and other reforms, so that too often I am compelled to say "I," when a different pronoun would be more acceptable to both speaker and hearer.

When I graduated from the Medical Department of the University of Pennsylvania in 1859, the condition of medical affairs in America was most deplorable, and reform in them seemed impossible. For more than a century the medical colleges, incorporated by the various States, had possessed the sole power of granting the degree of *Doctor Medicinæ* as well as of conferring the license to practice, and to deprive them of either franchise appeared so radical and revolutionary that no one, at that time, even proposed it.

Two nominal years of study—two courses of ungraded lectures, final examination by the same professors who had been teachers—an examination that most often was a mere farce—and out went an ever-increasing throng of doctors.

If such was the *status* in the best of our colleges, what shall I say of the worst?

No preliminary education was demanded. From the plough-tail to the pill-box through just one and one-half years of study, and the doctor entered upon the highest and holiest functions that life affords.

One essential I have omitted—the most essential of all. The tickets admitting to the lectures of each professor must be purchased by the pupil, and a graduation fee of twenty-five dollars paid. No wonder the number of medical colleges increased!

A cluster of medical friends would organize and incorporate under some general law, advertise liberally, and behold, a stream of gold!

I have heard it said that a professorship in some of our colleges was worth from eighty to one hundred thousand dollars. This may not be true, but it might well be, under the prevailing system. And so, American medicine became a "by-word and a hissing" both at home and abroad. Only one or two of our diplomas were recognized in England, Germany and France.

I wish it to be clearly understood that I am not speaking of all medical colleges, nor of all their "professors," nor of all our students. Our country, then as now, could boast unrivalled physicians, surgeons, professors—the peers of any of their time.

All honor to them!

They, as well as we, felt the burden of the system, and would have rejoiced—nay, *did* rejoice in its overthrow. I am condemning the system, not individuals nor individual institutions.

Early in the year 1868, with the aid of a young legal friend, I drew up a bill designed to effect a change in these conditions, and had it presented to our State Senate by Senator Thayer, of Troy, where I then resided.

I had no hope, and even less expectation, that it would accomplish much, but regarded it as a small step toward reform.

I was asked by Doctor Wm. Wright, the President of the State Society that year, to deliver the annual address for him. I consented, and spent my brief hour in arguing the provisions of this bill. The following day I asked and received for it the unanimous approval of the society. I then moved the appointment of a special committee to consider the measure, amend it, if wise, and press for its enactment into law.

Dr. Wright asked me to name that committee and I did so, putting at its head Dr. John F. Gray, of New York city, with others who afterwards "fought a good fight" in this reform.

It is not too much to say that Dr. Gray was the most powerful factor of us all in leading and perfecting this measure. He was a

man of the most commanding ability and influence. He was ably seconded by Doctor H. M. Paine, Wm. H. Watson and others. Dr. Paine was a most acute and persistent lobbyist, and over this measure worked day and night. Without the aid of these comrades my puny efforts would have failed. Lack of time prevents a narration of all the vicissitudes of this measure.

Briefly, it may be stated that in 1869 it failed to pass; the next year it passed and was vetoed; in 1872 it became a law. Its main features were as follows:

1st. Appointment by the Regents of one or more Examining Boards.

2d. As preliminary, candidate must show a knowledge of all that is taught in the high schools and of the Latin language.

3d. Three years of medical study.

4th. Examinations as at present day.

5th. Regents to confer the usual degree and license to practice.

These, in brief, were the salient features of the new measure.

So far as I know, it was the first law establishing State Boards of Examiners in America. And now nearly every State and territory in the Union has adopted this system with slight modifications.

The Homeopathic State Society was the first to demand and receive an Examining Board. Later, by about one year, one was granted to the "old school."

It will be noted that, under this law, the new boards had powers and privileges only co-ordinate with the colleges in conferring the M. D., as well as in the matter of license and, of course, found few candidates knocking at their doors.

Naturally, students chose the places where the fences around the public pasture were lowest, and adhered to the colleges. But the leaven had entered the meal, and it was destined, in time, to leaven the whole.

Then began what may be called a twenty-year war in the lobbies of the Capitol. The chief bones of contest were two:

1st. The separation of the licensing from the teaching bodies.

2d. The question of single or multiple boards.

The former of these was finally settled by the law of 1891, which took from the colleges the licensing power and gave it into the hands of the examining boards.

It was a long and strenuous battle, interesting but foreign to the purposes of this paper. It covered nearly twenty years. It took about seventeen more years to settle the second contest in favor of the single or mixed board. This latter has but just begun its career, and is too recent for comment.

It has been said by the State Commissioner of Education that this change was inevitable. Boards of examiners had become so numerous and burdensome that the legislators and regents were, in a way, compelled to place a check upon them.

Probably few of my hearers have any adequate idea of the work of the regents. Aside from their supervision of the public schools, they maintain and direct six boards of examiners; one of medicine, one of veterinary medicine, one of pharmacy, one of dentistry, one of accountancy and a registry of nurses. And there seems to be no end of similar bodies asking for recognition and protection in their various avocations, so that one cannot wonder that a limit in this direction must be found to the duties of this body of public-spirited citizens. They carry an ever-increasing burden at a great sacrifice of thought and time, and without fee or recompense.

We cannot honor them too highly nor be too loyal in their support.

One more feature of the new law demands a few words. It is regarding the elimination of Materia Medica and therapeutics from the examining curriculum. This seems to be rendered necessary by the adoption of the mixed board system, if we are to look for harmony in its action. To me it appears to be the "right thing in the wrong place," as will later be shown.

Of the present board, of which I am a member, I have only this to say: As you all know, it contains four "Old School" members, three Homeopaths, one Eclectic and one Osteopath. I judge them all to be able, educated and accomplished gentlemen, anxious first and most to promote the welfare of our profession. Nor can I see how, even if so minded, they could be swayed by partisan spirit.

Before leaving this part of our subject, it should be noted that the charter of the Homeopathic Medical College of New York provides for the examination of its candidates a board of "Censors," none of whom belongs to the teaching faculty, and from 1869 until the present date—nearly forty years—the said censors have performed this duty without fee or emolument of any kind.

So much for the past and present of medical examining boards in our country. Now, as to their future.

Though not a prophet, nor the son of a prophet, I venture to assert that the new system of State examining boards has come to stay. There will be no return to ancient customs and laws. Changes, more or less important, will doubtless be made, as time shows imperfections in the present laws, but the licensing power will never be restored to the teaching bodies. Higher ideals than those which now exist, more perfect methods and loftier standards may be confidently expected to prevail. Some of these I shall now indicate.

Permit me first to mention a few of the more prominent deficiencies of the present system, as they appear to me, and then propose methods for their relief or removal.

In the first place, in this State at least, the examinations consist of written questions and answers only, so that a candidate with a good memory often far outshines much abler and more competent rivals. Knowledge, often parrot-like, outranks good judgment and skill.

Second. Each State Board has standards of its own, and these are various.

Third. New and distinctive titles and degrees are needed.

Derivatively, "doctor" means "teacher," and that few doctors are. At least seven varieties of doctors exist in every community, so that this title is no longer distinctive.

Fourth. This system has shown no tendency to prevent overcrowding in our profession.

Other, and perhaps as important defects, are familiar to all.

Now, instead of discussing these defects in detail, which would be both tedious and unnecessary, I wish to outline in the briefest manner my ideal of a better system, and one which appears to me entirely feasible. The mere statement of it will, I think, carry its own affirmative arguments to minds as trained as yours. No doubt it will also develop objections, but I trust none that are vital.

OUTLINE OF IDEAL.—Although it is held unconstitutional to establish a "University of the United States," it is possible for Congress to establish one for the District of Columbia, and since Mr. Carnegie has offered an endowment for such an institution, I take its creation to be only a question of time.

Now, one department of such a university might be a medical and surgical examining board. Suppose, then, such an institution and such a board—I would utilize it in this way:

I propose that the medical student should be educated as now, obtain his degree of M. D., and then his license to practice from a State Board.

To qualify himself as a candidate for the proposed new title and degree, I should make it requisite that he should have also earned the degree of A. B. or Ph. D.

Having entered upon general practice and having pursued the same for say, five years, two of which should have been spent as an interne in some reputable hospital, he should then be eligible to examination by the said Board of the University of the District of Columbia.

The fee for such an examination should be a considerable one.

This examination should be both didactic and oral, but more than all, a practical one. The candidate should be able to name, and be proficient in the use of, instruments of precision in diagnosis or operation. In the wards of a hospital he should be required to diagnose cases of disease and to conduct cases of labor. In the morgue, he should be called upon to demonstrate and operate upon the cadaver, in case he desires a surgical diploma, not otherwise.

A "paper" examination should follow.

No question in therapeutics of any sort should be allowed. This restriction I deem absolutely indispensable, for it would at once destroy all present, and prevent all future, sectarianism in medicine. This is the "right thing in the right place," previously mentioned.

Having successfully passed these ordeals, he should be given one

of the following titles or degrees, viz: "United States Physician," or "United States Physician and Surgeon," or U. S. P., U. S. P. and S.

These designations are distinctive, unpervertible and easy of understanding by all.

All " U. S. Physicians and Surgeons" should, as such, be eligible to appointments in the Army and Navy without further examination.

Usurpation of these titles and degrees should be severely punished by imprisonment. Of course, to one possessed of such titles thus obtained, most civil and municipal offices and appointments would be open.

Such a system would be of the very highest benefit to the profession by stimulating the ambition of young practitioners, and make it really what it now is not—"a learned and liberal profession." It would create and perpetuate an aristocracy in medicine—an aristocracy of learning.

Its benefits in eradicating medical intolerance and bigotry would be enormous and lasting, while to the community in general, its blessings are too obvious for remark.

I will only add that while such an ideal may appear to some as the dream of an enthusiast, and one impossible of attainment, we need only recall the fact of the recent withdrawal of the licensure from medical colleges—a franchise they had held for more than a century. That victory is full of hope and promise for still greater reforms.

DISCUSSION.

M. J. LEWI (Secretary of the State Board of Medical Examiners): Mr. President, Ladies and Gentlemen, permit me to thank you for the opportunity and the honor of appearing before you. One of the gentlemen, a few moments ago, when I was fortunate enough to be present during the discussion on nervous diseases, made a remark which is very appropriate in this instance, and which means that Dr. Searle has covered the ground entirely. I was told a story some time ago, which some of you friends who are interested in insane asylums may find appropriate to this occasion—of some people who were being taken through a State hospital, formerly called an "insane asylum," and who came upon a person whom they took to be an attendant, but who was one of the inmates. They remarked to him, as he walked along with them, that the place was so remarkably quiet that one would not suppose it possible that people who were bereft of reason could be confined there. The supposed attendant replied, "Yes;" the place was very quiet and very peaceable; that they had people who were not so well as those in the wards and rooms on these floors, that the more severe cases were kept down stairs, but that the same quietude was observed

there. He said the wonderful part of it was that it was all done by system, and their system was that everybody should be occupied; everybody had a task to perform; that which was most congenial to his line of thought in his mental condition; and he said, "You would be surprised if I told you what my occupation is." "Well, what is it?" "Why, I am writing an index for a dictionary." (Laughter.) Now, my work in commenting upon Dr. Searle's paper would be very much like writing an index for a dictionary. He has covered the ground most splendidly. He writes incisively, epigrammatically, and he gets in all the meat in the smallest amount of space. Several years ago I had the pleasure and the distinction of being invited to address the Homeopathic Medical Society of the State of New York, and I prepared an address very much along the same line that Dr. Searle has pursued, but I was unfortunately unable to be in attendance; and I want, on this occasion, to express my thanks to the gentlemen of the Society for that honor, for I considered it such.

I do not know if many of you can go back twenty years—I see that some of you can—to note the difference in the trend of thought in the medical profession then and now. Dr. Searle referred to Dr. Payne. Dr. Payne lived in Albany at the time when I lived there. He was the secretary of the Homeopathic Society's committee on legislation at the time that I was secretary of the committee on legislation representing the Medical Society of the State of New York. We were residents of the same town and social friends at that time, but when the discussion of this bill which was passed, which became a law in 1891, first arose, Dr. Payne and myself were at swords point. Dr. Payne could go back to the time when the word "Homeopath" was a note of derision and scorn in the minds and hearts of the old school practitioners of medicine; he could go back to the time when the finger of scorn was pointed at him because he practiced Homeopathy, and Dr. Payne was naturally suspicious of people who came to him with the olive branch of peace. I realized early in the contest that the Homeopathic Society was going to win in its cause, and that the single board bill, which was advocated by the Medical Society of the State of New York, could not become a law; and together with Mr. Dewey, who was then the secretary of the Board of Regents, and was also State Librarian at that time, we took the homeopathic bill and the old school bill and merged them into a bill that we thought might be proper in case peace should be declared between the two factions. Dr. Payne was called into council, and Dr. Payne gave a willing mind, but a suspicious eye, to everything that was being done. He remembered the days of old, he remembered the time when everybody who belonged to a school of medicine different from that which he advocated was looked upon with suspicion; and although we were friends, social friends, in a higher sense than the ordinary acceptation of the term, still, when it came to matters medical, he represented the Homeopathic Medical Society of the State of New York, and nobody was

going to fool him. Well, Dr. Payne succeeded finally in having that bill amended to meet our views, and we in turn, to meet his, and that bill became a law and was passed in 1890, went into effect in September, 1891, and has been in continuous effect from that day until the first day of August last. How well we builded, you gentlemen of the profession can judge as well as I can state it. For sixteen long years the bill was carried into effect harmoniously. There was never a clash. And during all those years I want to say that the Homeopathic State Society did me the extreme honor, through its State Board of Medical Examiners, to select me as their representative, as secretary of the joint board. I was, and am, and will always be, duly grateful.

What is the future to give us in connection with the new bill? I had no part in the active warfare which terminated in the passage of this bill. I sat at my desk in New York city attending to my work, but I had a deep and abiding interest in the outcome, because I had fixed views on the subject. I know how through all these years, year after year, they came tapping at the legislative halls, representing every cult and every creed and every "pathy" possible, for the purpose of creating an additional board of examiners; the Hydropaths, the Electropaths, the Vitopaths, all classes of people—I do not recall their names at this moment—all came there and they said, "We want the same rights and we crave the same distinction that has been accorded to your three schools, the Eclectics, the Homeopaths and the Old-Schoolers." What was to be the outcome? The American people are a fair-minded people. I have great faith in their judgment, I have great faith in their honesty. There was but one thing to be done if a man or a set of men came and demanded honest representation, and that was to give it to them. "You have given the Homeopaths their rights, you have given the Allopaths their rights, you have given the Eclectics their rights. Now, we honestly believe in Hydropathy; we believe that all the ills that flesh is heir to can be cured by the application of water, if properly done. Now, we teach that, we teach it honestly, and we demand that you create a board, that our men shall have the same rights and the same distinction that these boards have." Now, that was being repeated. The osteopaths came with that call. From all sides, as I said, they came, and what was to be the remedy? In all fairness, they had to give these people representation, or they had to take it away from us who had it. There was but one thought possible, and that was a merger of the boards which existed; and how could this be done? If a Homeopathic examiner in therapeutics were to be called upon to pass upon the examination paper of a doctor of medicine who wanted to be licensed in New York State, as to whether he knew how to use aconite properly, as he had been taught in an Old School college, it would have been farcical, would it not? If, on the other hand, an "old schooler" were to be appointed to pass upon the qualifications of a man who had gradu-

ated from a homeopathic school, as to whether or not he was fit to practice medicine as based upon his knowledge of drugs as taught at a homeopathic school of learning, that would have been equally farcical. And the same thing applied to the eclectic school. So what was to be done? The elimination of the so-called seventh topic was the one thing to make peace in the ranks and to prevent any and all persons from coming in, unless they could prove they were scientific physicians. Now, that has been done in the law which is in full force and effect to-day. There has not been one single detraction from any single school of medicine or any method of practice whatsoever. The candidate is simply asked to prove that he has the scientific ground work which every physician should have. He must have had four full years of preliminary work in academics. That was to be the rock, the foundation stone, the *sine qua non*. He must have had four full years' education at a school which the regents' office recognized. And, mind you, gentlemen, the regents are not wedded to any one sect. They belong to all, and I believe if a vote were taken it would be found that those who predominate there are men who are surely friends of yours and of this State Society; so that the charge could not be lodged against them that they are sectarian as against any school, and more particularly the homeopathic. Here was the point to be gained, that four years of academic schooling should be required. I beg your pardon if I repeat myself. I did not come here prepared to speak to-day, I regret to state, so that what I am saying is extemporaneous, and I may not dove-tail here and there in my remarks. I am about through, however. Four years at a degree-granting medical school that the regents recognized as standard, and then an examination which would show that a man had a scientific training in the agreed-upon scientific features of medicine. Now, there is no difference in the anatomy of the human body. Whether you practice Homeopathy, Allopathy or Osteopathy, the human body is the same, and scientists all over the world are trying to find out new factors which exist in connection with it; so that we could all agree upon anatomy. The same thing was true of physiology, of hygiene, of sanitation, of chemistry, and so on down the line. Now, the regents' office said, and Commissioner Draper was the first to sound this note, "If you gentlemen will agree upon what constitutes the practice of medicine, regardless of what a man practices, we will set the pace." And so the State of New York has said in that law, "Gentlemen, we have given to the medical profession, and to the State of New York" (which is the most important thing; you doctors, of course, count, but the welfare of the State is paramount), "we have given you a law which will indicate that a man does or does not possess the qualifications to go before the public, through the title of Doctor of Medicine, to practice medicine." Now, beyond that we can trust the regents of the university, because they have insisted, first, that a man has an academic education; second,

that he has had a training at a school which has taught him how to practice what he knows, and there you are. That is the law of to-day.

Dr. Searle makes a suggestion as to the other. I have not had time to thoroughly masticate, much less digest, the thought to which he has given utterance. However, I can see much of good in it. If you will recall the fact that the insurance companies of the United States, realizing that the State laws will not permit, the intrinsic law itself of each State will not allow the United States government to step in and assume its prerogatives, that a suggestion was made in that connection that the District of Columbia organize through the Congress of the United States a system whereby a life insurance company could be created, and every company, if it was a good system, would want to have the right to issue business in the District of Columbia. In order to do that, it would have to pass exactions of the District of Columbia, which in turn would mean that every life insurance company would be entitled to do business in the District of Columbia, which would insure for it the stamp of Congress on its work, and that in turn would mean that they could go into any State and every city, and every official and every citizen of the State would feel confident that the law was all right, otherwise Congress would not have passed it. Now, something of this kind might be done by the United States government. It might establish a universal system, and the State of New York, the State of Pennsylvania and the State of New Jersey and a few others might get together and say, "Here, we will accept the standard which the United States government has set, and if any man comes from that territory to us, we will vizé his license and make him a doctor of medicine." New York State to-day is endeavoring, through the assistance of other states, Michigan and New Jersey already, and Ohio presently, to obtain reciprocity, a system whereby a man practicing in Michigan, who has been licensed by the board there, may come to New York State and practice here by having his license vizéd, and *vice versa*. But, gentlemen, that is foreign to the subject that is up for discussion. I simply mention it in passing.

While I am on my feet, I would like to utter a little idea of my own, which I trust you will pardon. The nobility of the practice of medicine has been touched upon. I do not think that even the profession which we look upon as even more sacred than our own—the ministry of the gospel—will gainsay the fact that there are some things that are equally noble in medicine. There are some things, Mr. President and gentlemen, in medicine that are grandly noble, which have never been brought out; and it rests with this decade, I hope, and certainly with this generation, to bring them to life. It is a noble thing for a man to go out and practice medicine, but it is a far more noble thing for him to go out and prevent disease. That should be the aim of the medical profession throughout this country, and more particularly in New York State, where we have set

the pace for other states in so many things medical. The suggestion has been made, and is to be acted on shortly, and I should like very much for the members of your Society to take this up thoughtfully, that the State of New York create the title of Doctor of Sanitation, or of Public Health, as the case may be, and that that title be an essential, after a given date not too far remote, say in 1915, for any man who wishes to be a public health official, unless he has served in that capacity previously; that the legislature of the State of New York pass such a law, and that medical men ask for it; and I do not doubt for one single moment that if the medical profession came unitedly to the legislature of the State of New York and said, "Gentlemen, we want a law that is for the benefit of the people, whereby we will get a man who is skilled in sanitation, who knows his work on hygiene, who is a Public Health Doctor and has earned his title," the State of New York would unanimously decide that that was the thing to do. I believe that if the medical profession would put its shoulder to the wheel on this proposition, it could stamp out forever diseases which we are treating every day, which are recognized as a menace to life and health. I believe it is our duty. We are citizens of the State. It is our duty to prevent disease where we can, and if the medical profession will do this, its crown will be, indeed, a more beneficent one than ever before.

WM. HARVEY KING: I have but very little to say on this subject. In fact, so far as the past is concerned, so far as the legislation we went through with last winter is concerned, I do not believe that the views of the Homeopathic profession are any different to-day than they were when they were fighting the bill at that time. But, gentlemen, that is a thing of the past, and the thing for us to do now is to look to the future.

Dr. Searle has announced that there has been a board of censors appointed since 1869 to examine students graduated from the New York Homeopathic Medical College. That is true. The suggestion first came from William Cullen Bryant, then president of the board of trustees, and he and Mr. Salem H. Wales, afterward president of the board of trustees were instrumental in getting that clause into the new charter. That, however, did not work. I am very sure it is not working as Mr. Bryant and Mr. Wales thought it would. The men who were appointed under that law were the best and the most honored men; there were none in the homeopathic profession of New York State who stood higher than they, yet they were friends of the institution, friends of the professors. They felt that their position was an honorary one to a degree, and never since my connection with the institution has there been a student turned down on conditions; but above all, there has never been a recommendation from that board of censors to the faculty. Now, faculties are very apt to get a great deal of criticism. In fact, they get criticism from all sides; they are apt to become callous regarding criticisms; but here was an opportunity for a board to give just criticism—standing in a position to give just criticism—

from men who would have been listened to. Yet, during the thirteen or fourteen years I have been on the governing faculty of that institution, there has never been one criticism or suggestion received from that board, and there has never been any conditioning of students. So that, so far as holding the institution up to the point that was intended for it, as based on the observations made by Mr. Bryant when in Europe, the University of Oxford, I think it has been a perfect failure.

Now, the suggestions which have been made here have been good ones, undoubtedly, but I think you will find that legislation has always been rather in the wake of the colleges in many ways. I am aware that the institutions have improved wonderfully under the influence and stimulus of the examining boards. All the departments have come up, every college has been on the qui vive to see that its students passed; yet there are certain defects in the present examining methods which do not hold certain departments up in a college. They hold the department of chemistry, of anatomy, of physiology, for instance, up to the highest point, and any college finding its students failing in those subjects, or in any subject, for that matter, is very careful to revise its standards, to change its professors, change its curriculum, in those branches. That is so in our own colleges, has been so in the past, and I know it is so in other colleges; and that has been of the greatest benefit in bringing colleges up in that respect. But there are other defects in the larger subjects, such as surgery and practice, in which the colleges are not held up to as high a point as they should be. For instance, take the department of practice, which includes nearly all the specialties, includes the specialty of kidney diseases, nervous diseases, skin diseases, and so on. (They have a system of fifteen questions, I think, and only ten of those may be required. Now, it has been notorious that some colleges have allowed certain departments, such as one of those specialties, or the eye and the ear and throat, for instance, in the surgical department, to fall down to the very lowest point. The student has his choice to select from. For instance, take the ear; there would never be more than one question on the ear in surgery. No matter whether the student knew anything about ear troubles or not, he could skip that one. There would be probably one question given on skin diseases. No matter whether he knew anything about skin diseases, he could skip that. And there have been some notorious failures of medical colleges to bring up the standard in certain specialties because they were grouped in large departments, and consequently they did not count in the final examination.

But, as I said a moment ago, I have generally found that legislation follows the colleges. The colleges instituted a three-year course long before legislation made it obligatory. The colleges instituted a four-year course long before legislation made it obligatory, long before the profession, or the legislature or the public at large had come up to the point of demanding such a law. Now, I

believe that if we are to obtain the advance which has been suggested here to-day, we must begin with the college first, and work up to the point where we will give practically what is demanded here to-day. Then the legislature will come along and take its place. I want to say here that so far as the New York Homeopathic Medical College is concerned, we are already making arrangements to take that course. The faculty has already considered it, a number of the trustees are to-day working on a scheme whereby we give a five-year course; a four-year course, the same as at present, and the fifth year to be given in the hospital connected with the institution, and which must be given in a practical way; practical so far as hospital work is concerned, and including also an advanced course of practical laboratory instruction in advanced physiology, pathology and bacteriology. That year is in advance of the four-year course, and for which a very rigid examination must be had; not so much a written examination, but a practical examination by the bedside on what has been learned in the hospital and in the advanced laboratory work. I think that will be instituted. In fact, the senior class of this year will be prepared to take that course next year, for which we will give a degree, perhaps, or some little distinction to show that the graduate has taken this advanced practical course.

I believe, gentlemen, that this must be the starting point; I believe that the colleges must start along that line and carry it up to a certain degree until the profession at large recognizes the necessity for it; until the public recognizes the necessity for it. Then you will find that the legislatures will be ready to take that step, either state or national, and pass such laws as will make these courses obligatory.

I do not wish to speak any longer here to-day, but I wish to say this, that the examining boards have done very much for the improvement of education in this State. That I can say as one on the inside. I know how often we have taken the list of failures in our own school, the list of failures in other schools. I remember some years ago we had a professor of chemistry whom the students petitioned again and again to have replaced, on the ground that they couldn't learn any chemistry. Finally the State law came in, and fifty per cent. of the students were thrown down one year. The faculty was not long in boosting that professor and getting another. Now, that is only one thing which comes to those on the inside of the faculty, where they are watching the State boards, and which is one of the reasons why I objected here to-day to the severing of all connection between this Society and the State Board of Examiners, so that we might have a report, and know exactly where our students stand. I believe this will go on and on until it will bring up the standard in every branch, which I have said to-day it does not.

JOHN L. MOFFAT: I want to present just one thought. I would like to have Dr. Searle and Dr. Lewi think of it. It is not new to

Dr. Searle and to others, but as it is a thought that is coming up now, it seems to me we might speak of it. I refer to the creation of the degree of Bachelor of Medicine. The increased course of work and study in the colleges has begun to be five and six years. I believe that, while it is difficult, it is possible that the four-year course as given now will in time lead only to the degree of Bachelor of Medicine, which will be surrounded by such restrictions as are deemed best, and then requiring one or two years in addition for the degree of Doctor of Medicine. I think that that thought would bear a great deal of study, and is bound to secure a great deal of study.

As to the other point that the last speaker, Dr. King, brought up—we all knew at the time that the present, lately-enacted law was adopted, that the State Board of Examiners was to do two things. It was to protect the community, but it was also to ascertain on the part of the government whether the college which had had a certain contract was living up to its contract. It was a test, and the Doctor (Dr. King) confessed that it had an effect upon the colleges for good to have State examiners. Now, I think we were all surprised extremely at the division of subjects made by the present Board of Examiners, the new one. Physiology and sanitation are divided and given separate examiners. It was perfectly feasible to examine in physiology and sanitation under one paper. The colleges do not make adequate distinction in their training, between physiology and sanitation, to warrant that division. It seems to me that if they were joined again, and the examiner in sanitation should examine on the eye and ear and certain specialties that the last speaker mentioned as being slurred, it would have a good effect in every respect. Then, it is known that if a medical student is not supposed to be examined in a certain subject, it is human nature to slur that subject.

Personally, I accept the new law cheerfully, but as a citizen of New York I still regret that the State has lowered its standard of examinations and is inconsistent in saying, "We want to find out whether you can practice medicine. We will license you to practice in medicine, but we won't examine you in the practice of medicine." It was simply a makeshift; it was a political compromise, and is being accepted as such; and the way out of it is that we must examine in therapeutics again in order to be the leaders; and in order to examine in therapeutics we have got to have this influence upon the colleges. The old school colleges now are teaching Hydrotherapy. There is no college of Hydrotherapy. The old school colleges are teaching Electrotherapy. There is no school of Electrotherapy. A proper teaching of Homeopathy in the old school colleges will do away with the friction between the two schools. It will be only justice to the patients of the present old school doctors that those men should have a little broader education. When that comes, then we can have one examination in therapeutics. I hope to live to see it.

RECENT AIDS IN THE DIAGNOSIS OF TUBERCULOSIS.

BY GEORGE F. LAIDLAW,
NEW YORK CITY.

The word "tuberculosis" was much used by the ancients, but for them it meant anything from a cancer to an abscess, and had no exact significance. With the revival of anatomical study by dissection in the seventeenth and eighteenth centuries, tuberculosis was gradually identified as a distinct disease, susceptible of diagnosis and associated with the wasting disease that had long been known as phthisis, or consumption.

The diagnosis of tuberculosis began seriously with the great revival of clinical medicine in the early part of the nineteenth century, and to this period of acute clinical observation we can assign the discovery of many diagnostic signs that we use to-day. The rise of the art of percussion and auscultation at this time gave great impetus to the physical exploration of the chest and thus it was that tuberculosis of the lungs and pleura were the first forms of the disease to be brought under diagnostic rule. The invention of the ophthalmoscope soon led, in 1858, to the discovery of miliary tubercles in the choroid coat of the eye, still a valuable diagnostic sign of miliary tuberculosis, though in these bacteriological days it is usually overlooked or forgotten. The introduction of the clinical thermometer, about 1850, revealed the characteristic tubercular temperature that remains to-day one of our most reliable clinical signs of tuberculosis.

About 1850 the microscope came into use, and the diagnostic interest of tuberculosis shifted from the clinic room to the microscopical laboratory. The microscope soon showed the tubercular nature of the so-called scrofulous inflammation of bones and joints, of scrofulous lymph-glands and lupus ulcer, of the laryngeal ulcers of phthisis, of scrofulous disease of the kidneys and bladder, of the testicle and cord, of the uterus and tubes and of chronic inflammation of the pleura and pericardium. The demonstration of the pathological unity of these diseases scattered all over the body was the triumph of the histological period. An important contribution of microscopy to the diagnosis of tubercular phthisis was the demonstration in the sputum of elastic fibers of the lungs. In the days before the tubercle bacillus, this observation was of inestimable value in doubtful cases.

A new era, the era of bacteriology, was inaugurated in 1882 when Koch demonstrated the microbic cause of all varieties of tuberculosis. This bacteriological era has contributed much to the diagnosis of the disease. First stands the tubercle bacillus, of absolute diag-

nostic value wherever found. The tubercle bacillus gives accuracy to the diagnosis of urinary tuberculosis formerly undreamed. Bacteriology combined with Quincke's lumbar puncture now makes a positive diagnosis of tubercular meningitis, differentiating it from the suppurative form and sporadic cases of the cerebro-spinal type. Bacteriology has also supplied the means of distinguishing the tubercle bacillus from other acid-fast bacilli. In circumstances where, by reason of its sparseness, the tubercle bacillus cannot be found in the ordinary smear, that is, in cases of early phthisis or peritoneal, or pleural exudate or curettings, or caseous lymph-glands or urinary tuberculosis, bacteriology has supplied the supplementary methods of culture and inoculation of animals. Culture on the original tuberculosis media being slow and technically difficult, media were devised by von Hesse and Jochmann for the rapid cultivation of the bacillus for diagnostic purposes and these media have proved extremely useful. However, the simplest and most reliable test of the tubercular nature of a given fluid is the intraperitoneal injection of a guinea pig. Guinea pigs are so easily kept and fed and they are such ideal test animals for tuberculosis that one wonders that they are not more frequently employed.

Great as were the contributions of bacteriology to the diagnosis of tuberculosis, it left several gaps unfilled. There were the cases of early phthisis before expectoration or, if expectoration, before the breaking down of tubercles and the liberation of tubercle bacilli; that is, bacteriology gave no help in the diagnosis of the disease in the stage in which it was most important for the patient to be placed under treatment. There was also miliary tuberculosis in which the cultivation of the bacilli from the blood presents many technical difficulties and a large percentage of failures. There was peritoneal tuberculosis and lymphatic tuberculosis to be distinguished from lympho-sarcoma and Hodgkin's disease, and tuberculosis of the prostate and testicle. The microscope had carried tubercle diagnosis to its morphological limit, and there was no further progress until the chemist appeared and developed the chemical side of bacteriology.

The chemical period in tuberculosis began in 1890, when Koch caused fibrosis of tubercles in a guinea pig by injecting the chemical products or toxins of the bacilli, and in 1895, when von Behring discovered in the blood a naturally produced chemical antidote to the bacterial toxins of tetanus and diphtheria. Concerned at first purely with therapeutics, the chemical products of tubercle bacilli soon entered the field of diagnosis by virtue of their power to cause a specific reaction when brought in contact with tubercular tissue. This reaction consists in an access of pain, heat, redness and swelling and exudation; in fact, all the classic signs of inflammation, and is shown only by tubercular tissue. It is best seen and was first observed in lupus ulcer. It takes place in all tubercular tissue, and is especially well marked in pulmonary tuberculosis, where the inflammatory reaction can be detected by the physical signs. Coin-

cident with the local reaction are the constitutional symptoms, chief of which is a rise of temperature with or without chill, aching of the bones, nausea, vomiting and prostration. In homeopathic language there is a marked aggravation of the symptoms pointing to the homeopathicity of the drug. I might remark, in passing, that this homeopathicity is only apparent; for tuberculin never produces these symptoms in the healthy. It is a matter of sombre satisfaction to the homeopathic logician that this drug that does not produce the symptoms in the healthy, does not cure the disease. As far as our knowledge extends, there seems to be an exquisite homeopathicity about these bacteria and their toxins, and they are not interchangeable. Small doses of tuberculin will protect against large doses of tuberculin, but not against the bacilli. Dead bacilli will protect against dead bacilli, but not against livings ones. The best protection and cure for infection by living tubercle bacilli is inoculation with a feeble but living tubercle bacillus, and it is the hesitation that we all feel against injecting living tubercle bacilli into human patients that delays the development of this most promising isopathic treatment of tuberculosis. This by way of parenthesis. We will return to the diagnostic value of tuberculin. The characteristic reaction occurs with all the preparations of tubercle bacillus which have been introduced, whether it be the old tuberculin or T. R., or the bacillus emulsion, or the sera of Maragliano or Marmorek, but the old Koch tuberculin gives the most constant results. Nearly all cases of tuberculosis will react if the dose is large enough. Exceptions are advanced cases, of which the explanation is that they have already reacted to the tuberculin in their own bodies so often that their capacity for reaction is exhausted. It fails also in encapsulated, that is, healed tuberculosis. On account of the liability to too strong reaction, hemorrhage, fever and prolonged aggravation, the initial dose should be small, two-tenths of a milligram of old tuberculin. Löwenstein and other observers have pointed out that the first dose of tuberculin sensitizes the tubercular tissue so that for some time it will react to smaller doses than before.* This phenomenon was commented on editorially in a recent number of the *Medical Record* in relation to diphtheria antitoxin, pointing out the danger of administering a large second dose soon after the first. In suspected cases that do not react to the first injection, a practical rule is to repeat small doses several times, rather than to increase the dose too rapidly. A dose of two-tenths of a milligram every third day for four doses will give positive results.

As already stated, the reaction is both local and constitutional. In miliary tuberculosis and meningitis, and some cases of glandular tuberculosis, the constitutional signs of chill, fever, nausea and prostration must be relied upon. In lupus, the local reaction is the best guide. In pulmonary phthisis, as Dr. von Ruck has long insisted, the local reaction in the lung is readily recognized, requires less

*Zeitschrift für Tuberkulose, Mai, 1907, p. 45.

dosage and is therefore a safer guide than the constitutional reaction. It is determined by increase in the physical signs of the affected area, extension of percussion dullness, and especially, crepitant and subcrepitant rales, increased cough and expectoration, and perhaps hemorrhage. The signs of reaction appear in from six to twelve hours, and continue for three or four days.

If doses of two-tenths to one milligram are not exceeded, there is practically no danger. Accidents which have occurred with larger doses are hemorrhage, increased fever and prolonged ill-health, the patients never regaining their former condition. These accidents are due to too large and too frequent doses. With his respect for the aggravation, and his confidence in its curative power if allowed sufficient time to expend itself, the Homeopath is less likely to make this mistake than the more crude non-Homeopath with his daily large doses.

The Opsonic Index.—The work of Professor A. E. Wright, of London, has been widely discussed during the past three years. The so-called opsonic index has been applied to the diagnosis of tuberculosis in three ways. First, the blood serum of the patient with localized tuberculosis has much less opsonic power than healthy blood. Many observations confirm this fact, but the reports are still contradictory, and as yet the question cannot be said to be beyond dispute. The question is complicated by the fact that every little constitutional disturbance will raise the opsonic index to the normal or above it, and this is especially true of tubercular phthisis.

The second application of the opsonic index to diagnosis is the behavior of the blood serum of a tubercular patient after an injection of tuberculin or bacillus emulsion. For twenty-four or forty-eight hours, there is a marked fall in the opsonic power, followed by a rise. This does not occur in non-tubercular patients.

The third application of the opsonic index is best adapted to surgical tuberculosis and tubercular peritonitis. In a strictly localized tuberculosis, as that of bones, joints, lymphatic glands or peritoneum, the tissue juice of the tubercular area has much less opsonic power than the blood serum of the patient. In other diseases the tissue juice and the blood-serum have equal opsonic power. This enables us to differentiate tubercular peritonitis from cancer or the ascites of other causation, and should be of value in recognizing tubercular otitis.

The Blood.—For years, microscopists have sought some characteristic sign in the blood by which tubercular infection and cancer could be recognized. Except the tuberculin reaction which is chemical, no reliable indications have been found. The occasional papers in medical journals of enthusiastic observers claiming the discovery with the microscope of a diagnostic sign of tuberculosis in the blood, have been premature, and such power is only claimed by charlatans and the self-deceived.

Arneth's blood pictures, which consist in the arranging of the neutrophile leucocytes according to the number of their nuclei in

groups of one, two, three and four nuclei, are undoubtedly important in prognosis, but have no diagnostic value, since the same features are seen in cancer and many other diseases.

The recent aids to the diagnosis of tuberculosis that remain to be considered are the agglutination test, or serum diagnosis, cyto-diagnosis, d'Espine's sign of enlarged bronchial glands, the long-neglected Krönig method and the X-Ray.

The agglutination test is similar to the well-known Widal reaction of the blood serum of typhoid fever, and is adapted to all forms of tuberculosis. As a diagnostic sign, it is unreliable. Some healthy blood sera agglutinate tubercle bacilli strongly, and tubercular sera present all degrees, from strong to feeble agglutination.

Cyto-diagnosis is applied to exudates, as in suspected tubercular pleurisy, peritonitis and cerebro-spinal meningitis. The indefatigable Widal observed that tubercular exudates contained a preponderance of mononuclear leucocytes, inflammatory exudates, a preponderance of polynuclear leucocytes, and mechanical transudates, and those of malignant disease a preponderance of endotheial cells. Widal attempted to elevate this observation to the dignity of a diagnostic sign, but more extensive observation has shown that mononuclear and polynuclear leucocytes preponderate in proportion to the age of the exudate rather than the specific cause. All fresh exudates have an excess of polynuclear cells. This condition gradually changes to an excess of lymphocytes. Tubercular exudates being usually of a chronic character, therefore usually present a relative excess of lymphocytes; but this is no specific sign of tuberculosis.

d'Espine's sign of enlargement of the mediastinal and peri-bronchial lymph-glands is described in his article in *Tuberculosis* for May, 1907. If you auscultate the voice with a stethoscope of small aperture, as the usual binaural, over the lower cervical vertebræ, having the patient say "99," you will hear loud tracheal vocal resonance, as shown by Laennec many years ago. This loud vocal resonance ceases abruptly at the level of the seventh cervical spinous process, where the lung commences. The roots of the lungs with their clusters of lymph-glands lie directly in front of the upper dorsal vertebræ. Any enlargement of these glands transmits the bronchial vocal resonance to the adjoining vertebræ, and can be recognized with the stethoscope by extension downward of this increased vocal resonance to the spinous processes of the first, second, third and fourth dorsal vertebræ. It is a sign of special importance in children, because pulmonary tuberculosis in children is probably first expressed in the lymph-glands at the roots of the lungs, and often runs its entire course there. I know nothing of this sign more than I have read in the article referred to, but know from my experience with the Krönig percussion method the importance of studying the upper dorsal vertebræ in early tuberculosis. The sign is so plausible that I have felt warranted in bringing it to the attention of others who have the interest and opportunity to verify it as I hope to do

also. d'Espine finds it constantly present in tuberculosis meningitis and surgical tuberculosis of children.

Of the value of the Krönig method of percussing the apices in the diagnosis of early phthisis, I have often spoken and, after five years' experience, can only endorse it more strongly. With a light percussion-stroke, the width of each apex of the lung normally is two and a half to four inches and equal on both sides. Widths under two and a half inches, and especially unequal widths, are extremely suspicious. If the inequality is well-marked, it is a certain sign of retraction of one apex, and this is practically always tubercular.

The X-Ray is applicable to the diagnosis only of phthisis, and tuberculosis of the bronchial or mediastinal glands. While I think that in the majority of cases early phthisis can be disagnosed as well or better by percussion of the apices, especially by the Krönig method, I must admit that, in doubtful cases, I am very glad to have my opinion reinforced by a radiograph. Fluoroscopic diagnosis in the office is a matter of interesting confirmation of physical signs, but requires a practised eye to interpret what is seen. In everyday work, it can never, and should never take the place of accurate percussion. To yield satisfactory result, radiographs, too, must be both taken and interpreted by an expert.

The restricted motion of the diaphragm on the affected side, to my mind, is also only a confirmatory sign, and of less value than a radiograph or delicate percussion. I have studied the motion of diaphragm with the fluoroscope many times, but have been able to detect this restricted motion only in cases that were easily diagnosed by percussion.

In summing up the various methods of diagnosing tuberculosis, I would classify them as follows:

I reject the spirometer, cyto-diagnosis, the serum agglutination and all diagnosis by examination of the blood.

I give first place to the tubercle bacillus supplemented by culture on von Hesse's medium and inoculation of the guinea-pig; but in phthisis, expect to make the diagnosis by accurate auscultation and percussion, the Krönig method or the tuberculin test before the bacillus appears in the sputum. X-Ray diagnosis is of secondary importance. On the other hand, the presence of miliary tubercles in the choroid of the eye is of first importance in the diagnosis of miliary tuberculosis.

The opsonic tests and d'Espaine's auscultation of the vertebræ are still insufficiently verified.

REPORT

OF THE

BUREAU OF SURGERY.

"Pyæmia following Vaccination," - - - - - - ORANDO S. RITCH.
"The Value of the Leucocyte Count in Surgical Conditions," - - - - - - - - - - - WARREN C. DALY.
"Popular Errors Regarding Nephroptosis," - - - SIDNEY F. WILCOX.
"Hyoscin, Morphine and Cactin Anæsthesia," - - CHARLES E. WALTON.
"Surgery and the Public," - - - - - - - WILLIAM F. HONAN.

PYÆMIA FOLLOWING VACCINATION.

ORANDO S. RITCH, M. D.,
BROOKLYN, N. Y.

I present this subject for consideration on account of the fact that marked pathological phenomena are a rarity following injection of bovine virus into the human body, according to the methods of preparation, preservation and operation to-day, and also in marked contrast to those painfully disastrous results and complications following the use of human virus for immunity from variola.

I propose to give a brief description of the inflammatory process up to the period of suppuration, a pen picture of pyæmia, a thought on the theory of vaccination, and narration of a case.

Inflammation means preternatural heat, and when present has five symptoms in evidence, and any one of these alone will not express or explain the morbid phenomena. They are: Hyperæmia, heat, pain, redness and swelling. The phenomena of inflammation will be arranged under fourteen different heads in order to obtain even a fair conception of this process without entering into the minute surgical pathology. First, irritation; second, contraction; third, dilatation of the vessels; fourth, acceleration of the blood current; fifth, retardation; partial or complete; sixth, redness; seventh, swelling; eighth, heat; ninth, pain; tenth, escape of contents of vessels; eleventh, cell proliferation; twelfth, formation of pus; thirteenth, reorganization of tissue; and fourteenth, cicatrization and healing. These changes embrace the pathological cycle necessary to induce inflammation from the time of injury to the end of the process.

In a very brief way, these changes mean: First, as to irritation,

which is anything that affects the capillary vessels, a blow, bruise, cut, or the action of any irritant. The result of irritation is the contraction of the vessels for protection; when they contract the second effect is produced, which causes dilation of the vessels and results in congestion, following which is the fourth step, an increase in the flow of blood to overcome the stagnation, which may be partial or complete. This retardation, or plugging up of the vessels acts as a foreign body and sets up four more symptoms—heat, redness, swelling and pain. At this stage the inflammatory process is active. As we go on we find the vessels cannot withstand the pressure, and they give way, thus explaining the tenth step—escape of the contents of the vessels. This naturally fills a space called cell proliferation, and these cells being active and inflamed, break down and the twelfth is noticed—pus formation. With the escape of pus, nature reasserts herself, and starts in to reorganize tissue, and as the irritation is reduced, she succeeds; and when the parts are healed we have noted the fourteenth change in inflammation.

After the inflammatory process has advanced far enough to include the cardinal symptoms, a differential diagnosis must be made by the subjective and objective symptoms in each case, and in line with the title, advanced septicæmia, sapræmia and pyæmia are presented for elimination. Perhaps I might add, by way of the further elimination of the possible complications which may follow vaccination, a typical picture of the vaccination process. A few days after vaccination a papule is observed with a red areola at the point of attack; this increases in size and soon becomes umbillicated; the vessicle is circular and filled with lymph. This soon becomes purulent, followed by desiccation, the scab separating subsequently, leaving an indentation or pit.

The following complications have been noted through medical history: Erythema, urticaria, conjoined bullous eruptions, erysipelas, lichen urticatus, erythema multiforme, general vaccinia, impetigo, vaccinal ulceration, glandular abscess gangrene and septic infections. It would seem that none of these complications enter into a diagnosis by exclusion, save the last—septic infection.

Septicæmia is a morbid condition due to the presence of pathological bacteria in the blood. Billroth has well said: "Septicæmia bears the same relation to infective traumatic fever that pyæmia does to morbid suppuration." The absorption of bacterial poison is productive of active and marked constitutional symptoms, which in from a few days to two weeks results in either resolution or dissolution. Perhaps I might be permitted to coin the expression, in relation to sapræmia, as "fulminating septicæmia," in that it has reference to the toxic effect of septicæmia. This condition is usually announced by a sudden rise of temperature during the progress of an attack of septicæmia without a chill. Marked delirium, diarrhœa, cold, clammy skin, and the rapid approach of death are significant features. While many of the constitutional symptoms of these three diseases are similar, yet the severity, acute duration and the mani-

festations of danger of rapid dissolution would, without entering deeply into the minute pathology, eliminate septicæmia and sapremia from further consideration in this paper; yet, as Ogston broadly suggests, in infective inflammation, septicæmia, sapremia and pyæmia are different phases of the same disease.

Pyæmia, tersely speaking, is a complication of suppuration; it is an infectious disease and is developed during suppuration, being caused by the absorption of pyogenic micro-organisms into the circulation through the medium of the lymph channels. It is characterized by frequent chills, a fever, intermittent in type, and the formation of multiple or metastatic abscesses which are noticed in different parts, upon and within the body. The literal meaning of the term is "pus in the blood," and pus in the blood has the power to form multiple abscesses. The theory of such an abscess is that bacteria, gaining an entrance into the circulation, so acts upon the blood that minute accumulations form in the current, which are named emboli. As this little conglomerate body floats along, destined to create destruction, it meets obstruction in the capillaries usually, and being infectious it sets about doing its work, and as often as there is an infective obstruction of this character, be it small or large, abscesses will develop. The disease is usually chronic in character, prognosis is always grave, and in the final analysis about all the cases prove fatal.

To be very brief, and not to digress too far from the tenet of this Bureau, permit me to remark that vaccination is a process by which a specific disease is introduced into the human organism for protection against a far more severe disorder. The theory is fully elucidated in Jenner's masterpiece of medical induction: "Inquiry into the Cause and Effects of the Variolæ Vaccinæ."

Jenner established the following facts: That this disease, cowpox, casually communicated to man, has the power of rendering him unsusceptible to smallpox; that the specific cowpox alone has the protective power; that cowpox may be communicated at will from the cow to man by the physician; that cowpox, once engrafted in the human subject, may be continued from individual to individual by successive transmissions ferring on each the same immunity from smallpox.

Fundamentally these deductions stand to-day, with the exception of his last assertion, out of which grew inoculation by human virus, with its manifest and untold destructive complications, and from this perversity developed the modern and practically universal application of the pure bovine virus of to-day. In some portions of England, as Gloucester, where compulsory vaccination is not enforced, continual outbreaks of smallpox are of quite frequent occurrence, while here in our own borough, for example, where it is compulsory, smallpox for a number of years has been held in absolute check, and while twenty years ago, and previous to that time, it was the usual condition for a large number of cases to appear in a year, and many doctors in those times would see a case occasionally.

Under the present strict regulations, smallpox is becoming so rare that when a case does present itself the general practitioner will have to send for the expert to share the responsibility of diagnosis. Jousset states that before the advent of vaccination, smallpox claimed one-tenth of the population.

Regarding the administration of triturations of vaccine virus as a prophylactic, time alone can prove its value, and to become scientifically popular it must, of necessity, be confirmed by large practical experience. In view of my own recent disastrous experience, I am still a firm believer in and advocate of the present popular method of vaccination.

Miss B., aged 29; weight 167 pounds; well developed physically, and in her usual good health, was, on January 9, 1906, vaccinated on the left arm, according to regulations of the Health Department. On the morning of the 11th, patient felt a very stiff sensation in the left shoulder with marked evidence of a severe inflammatory process encircling the point of vaccination, and becoming more severe in the afternoon. At this time she was stricken with a severe chill followed by a high fever; the pains gradually became more severe and the inflammation spread over a large area. This, in brief was the history when I first saw the case, January 18th. Her pulse then was 108, respiration 28, temperature 103.3. She complained of a stinging, burning pain in the supra-clavicular region of the left side, and there was evidence of acute local pyæmic symptoms. It was observed as the point of supra-clavicular inflammation increased, the inflammation at the site of vaccination gradually disappeared, the wound dried over and this point was not involved again. The supra-clavicular condition progressed to rapid suppuration and the abscess was thoroughly opened curetted, and loosely packed, though with no amelioration of the general symptoms, as the chart showed respiration 28, temperature 100.3, pulse 120 to 164. Within a few days a new focus was formed, and an abscess developed rapidly just above the outer and upper circle of the left mamma. This was opened, but it soon burrowed under the breast, destroying the gland and reaching nearly to the ensiform cartilage; the pockets were opened and in several instances were anticipated. Now, the supra-clavicular pocket had burrowed under the clavicle and pectoral muscles, and the left side of the thoracic wall was under antiseptic treatment. When it seemed as though this long sinus was under complete control, the patient was seized with a heavy chill, and in a few hours experienced a sharp stinging pain over the belly of the right deltoid; there was also pain over the lower portion of the triceps and over the flexor sublimus digitorum. At these three points suppuration was promptly established, and each abscess was in turn opened, curetted down to what appeared to be healthy tissue, and in a few days there was a continuous opening from the upper portion of the arm to the middle of the forearm. The wounds of the right arm gradually healed and remained permanently so. The incision over the left chest was gradually healing when the patient was again

seized with a sharp pain in front of the right ear, which point, taking the usual course, was opened, cleaned and loosely packed, but nevertheless continued to burrow inwards and entered the buccal cavity. This wound healed promptly, but some weeks later broke out again, finally healing permanently. Next, a sharp pain was felt in the left axillary region and mid-axillary line over the eighth rib, near the border of the serratus magnus. The supra-clavicular wound was now healed, but the sinus under the pectoral and subscapularis communicated with the axillary involvement, producing a wound reaching from the top of the shoulder to the eighth rib. The usual treatment was adopted, resulting in a permanent healing of the axillary abscess and all sinuses in that region. The sinus over the posterior portion of the eighth rib burrowed downwards and backwards, and the patient was again afflicted over the lower border of the soleus of the left leg which resulted, before healing was complete, in an incision reaching to the tendo-achilles. The wound in the lower chest burrowed through the lumbar aponeurosis, then to the vertebral aponeurosis over the erector spinæ, as demonstrated by the probe and the development of four pyæmic centers, extending to below the crest of the illium posteriorly; and here is where I met the beginning of my Waterloo. The lower and left side of the back and loin was freely opened and treated in the usual manner through its tortuous channels. From this time on no more abscesses appeared. During the course of the case the patient was subjected to twelve different operations, placed under anæsthesia twenty-eight times, with painful intercurrent dressings, sometimes occupying over one hour at a time. She died June 18, 1906, thoroughly emaciated, exhausted and anæmic, enveloping one of the most trying cases of my career.

Treatment and Remarks.—Dr. Simmons was called as consulting physician. Homeopathic remedies, prophylaxis, antisepsis, and other aids were employed. The principle remedies were arsenicum album, carbo-vegetabilis, and echinacea, the last named being used in five-drop doses of the tincture, the others in varying potencies. Tissue remedies were employed, and intercurrent remedies from time to time as demanded. In the latter stages, morphia sulph. in ¼-grain doses, trional in X-grain doses, strychnia as strong as 1-30 of a grain were given hypodermatically as compulsory auxiliaries. Strong nutritious diet and plenty of stimulants, consisting of whiskey, white wine and champagne, were used also. Panopenton, peptomangan, protonuclein. The rapidity with which suppuration would appear led me to believe that the infraction was always in the capillary circulation, and there seemed to be no way of prophylaxis by ligation of vessels, but to deal vigorously with septic foci as soon as it was manifest, the modern methods of asepsis and antisepsis being strictly adhered to. The patient developed characteristic systemic symptoms of severe chill, and sometimes for days there would be chill, fever and sweat; and if there had been an idiopathic deep-seated condition, one might have thought of a plasmodium of

malarial tendency. The bowels were constipated, tongue dry and furrowed and a deep yellow, with a heavy coat. All the hieroglyphics known to chart-writing were transcribed from time to time, the most exaggerated being a change in twelve hours in temperature from 105 in the morning to 96 in the afternoon, holding a pulse of 94 and respiration of 28. There was no metastasis to any of the internal organs, although I expected such a result from the severity of the case. Constant urinalysis revealed no kidney lesion, the specific gravity never being above 1025, reaction acid, sometimes a trace of albumen, generally excess of phosphates, and nearly always some pus cells. Repeated blood counts demonstrated a marked hyperleucocytosis, the count averaging 25,000 per c. m. Toward the end of the case a hypoleucocytosis or leucopenia was present, with a count as low as 4,000. The patient was isolated, was given abundance of fresh air and water, and all known devices were brought into use as circumstances demanded, and thus the case ended.

DISCUSSION.

GEORGE C. JEFFERY: It is not necessary for me to say that this was an interesting paper, and presented to us in a very interesting manner. The case was unusual, and probably in looking back in our practice for any number of years, none of us will find a case duplicating the one which Dr. Ritch has reported to us. I have had several thoughts enter my mind as the Doctor was reading his paper, and one was this—whether I could technically agree with the diagnosis of his case. As I understand pyæmia, it is an infection of the blood by the bacillus of pus. It is a disease not only fatal, but very rapidly fatal; while in the case under consideration, I believe the poor sufferer lingered for three months. The matter of the vaccination is not the interesting part of the paper. The interesting point of the paper is, What was the peculiar form of infection which entered into the development of symptoms which the Doctor has so clearly elucidated to us? Now, if I may base my statement largely upon my own experience—and yet I may not be correct according to the text-books—I believe that if this had been a case depending entirely upon the infection entering the wound made by the scalpel as a part of the process of vaccination, that we would have developed the first abscess that Dr. Ritch speaks of. That first abscess would have been evacuated, the wound would have been treated antiseptically, as I know the Doctor would have treated it, and that would have been the termination of the case. The patient would have recovered. But that is not the history of this case, ladies and gentlemen. Dr. Ritch reports the first abscess. He opens that abscess, he washes it out and packs it loosely. But no sooner has that been done than new suppurative processes begin in close proximity to the original pus cavity. The same processes follow there. It is but a very short time, in fact, before the wound has

healed from the operation at the second point, before we have a third point beginning. I do not believe, ladies and gentlemen, that that follows the course of a pyæmia. I do not believe that this was a case of infection of the blood. I believe it was purely and simply an infection of the lymphatic system. What would induce or make possible such a condition in any one? Assuming this patient was a healthy woman, as I said at the beginning, the first evacuation would have ended the case. But she was not a healthy woman. There were conditions back in her system which provoked and carried on, independently of every effort made by Dr. Ritch and Dr. Simmons, conditions that brought a fatal termination, which meant that the patient died eventually, not of a pyæmia, but of an infective fever, and was worn out by the rise of temperature for a period of three months. I knew the patient. Through the courtesy of Dr. Ritch I was permitted once to call upon her, not in a professional capacity. I was closely related to her professionally, as many others of us were, and I would be the last man to cast any reflection upon her good name; but I believe, gentlemen, there was a syphilitic basis in this whole case. We all know how prone syphilis is, not only to attack the glandular system but to remain in the glandular system. We know how a primary lesion in syphilis is taken up by the lymphatic vessels and continued in the lymphatic system until it passes from the secondary into the tertiary stage. I do not believe there was any other condition that would have permitted the long continuation of this case, and the successive involvement of every lymphatic gland in this woman's body. They started, one above the clavicle; they came down into the back, went down into the loins, and finally an incision was made that extended to the tendon achilles. Any ordinary anatomist sees in his mind a picture of the lymphatic vessels and glands. I do not believe any condition short of a syphilis lying within this woman's body would have resulted in these complications of the primary infection.

M. R. LEVERSON: I asked privately for my time to be extended, but learning that it cannot be, I cannot go into this as I should like. I brought down with me a large number of drawings, about one-twentieth of what would appear in the atlas in my work on vaccination, and although I cannot hand them around in consequence of not being able to give explanations beforehand, if any lady or gentleman present would like to see them, I should be very happy to show them. I will just exhibit one plate containing two illustrations of pyæmia on the authority of Hutchinson, as rabid a vaccinationist as our friend Dr. Ritch. The deaths occurred a considerable time after. I have cases which will interest any who pay any attention to the subject at all, which I should be very glad to show you. In yesterday's *Times* there is another case reported under the caption, "Dies after Vaccination." There, too, the authorities seek to throw the fault on anything except vaccination. Now, let me ask you—you are all doctors, you know what sepsis means, and yet when the word "vaccination" comes into your minds you entirely dis-

connect it—and yet let me ask you what the process of vaccination is. It is taking septic matter, than which nothing can be thought of more septic, to introduce into the system. To talk of doing that, and at the same time using "strict aseptic precautions," seems to me such folly as philosophers of Lilliput might indulge in, but not worthy of medical men. I confess that a Homeopathic society is the very last in which I should have expected to hear such a paper as we have listened to.

HORACE PACKARD: May I ask Dr. Ritch if the form of micro-organism was determined in his case as the cause of the trouble.

DR. RITCH: There was such an examination, but I have not the report with me and I do not recall it; but the examination was made and is shown on the record at the hospital. Such an examination was made repeatedly. It was more that point I wanted brought out, as to the cause producing this condition. Of course, we can take up all the forenoon on it. I do not agree with Dr. Jeffery, however.

DR. PACKARD: I may be permitted perhaps to explain very briefly why I asked that question, because I have just come from London, arriving day before yesterday, where I have been in the midst of vaccine therapy, which, as you know, has been brought to the front by Professor Wright at the St. Mary's Hospital; and I must radically disagree with what some of these gentlemen have said in condemnation of vaccination. It is the utmost and foremost and most out-and-out Homeopathy that has ever come to the medical profession; and the fault in this case was not from the vaccine virus, but it was from some other material that was introduced with it. Vaccine virus does not produce any such train of symptoms as was exhibited in this case. To be sure, there is that danger in vaccination, from vaccine virus. However, it looks now, from what I have been able to learn, as though we shall be able to immunize our patients against smallpox in the future without the use of living vaccine virus, that the dead bodies of the vaccine material, if it can be cultivated artificially, will do just as well for immunization as the living virus, and save our patients from this danger which has menaced them in the past.

DR. JEFFERY: I do not want to be misunderstood here. I have said nothing against vaccination. I did not discuss the matter of vaccination whatsoever in my remarks.

DR. PACKARD: I wish I had opportunity to tell you what I have seen in this matter but it is impossible at present.

CHARLES MCDOWELL: As a firm believer in the efficacy and wisdom of vaccination, I wish to call attention to the fact that a case such as this shows us the importance of extreme care in that procedure. Vaccination is a surgical operation, and should be performed with great care, for the reason that, as in any other operation, there is a possibility of infection, not only in the operation itself, but in the care of the vaccination wound, or lesion. There is a constant possibility of infection, and cases such as this, cases

such as that related in yesterday's paper, rouse the opposition of many people to this most useful practice. Many physicians, even health board physicians, are at times hasty and careless in the performance of the little operation of vaccination, and patients are not cautioned as to the great care they should take in the matter. In the case reported yesterday the parents did not follow the printed instructions given by the health department, in several respects. Children frequently scratch their vaccinated arms. Childrens' finger nails are often dirty, and thus it is the easiest thing in the world for infection to follow. Comparatively speaking, there are, to be sure, very few of these accidents. For example, only a few years ago—I think it was in 1902, the health department of this city alone vaccinated more than 800,000 people, and yet very few accidents followed. It would not be strange if some of those 800,000 children and adults became ill or had some accidents following vaccination. In Germany every year they vaccinate many millions of people, and careful records are kept, yet the fatalities are extremely few. When we compare the conditions, we find the evils of vaccination very slight as against the awful evil of smallpox in those days. We cannot conceive of the state of affairs in old times. For example, in Prussia for twenty-five years previous to the introduction of vaccination, the average death rate from smallpox was more than 3,400 in a million. In Sweden, where smallpox was comparatively rare, the death rate was more than 2,000. Applying the death rate of Prussia to this city of New York, with four million inhabitants, we would have every year more than 12,000 deaths from smallpox, besides a large number of people who recover from smallpox with shattered health, disfigured faces, blindness, deafness and various other infirmities. Nevertheless, we must recognize the danger attending vaccination, seldom though it is manifested, and we must use the extremest care in the operation, and see that the people also are educated to a like great care.

E. D. FRANKLIN: I also believe in vaccination, yet I am perhaps astride the fence as between vaccination as usually administered and the giving of the virus internally. I have attended a number of cases of smallpox, and in one case particularly, on account of the condition of my family, I administered the virus in the fourth centesimal attenuation by the mouth. At that time my wife had a slight abrasion on her lip, and afterward the most beautiful vaccine pustule, and went through the course as though I had really vaccinated her on the body, to which she objected because of her experience in early years when vaccinated with human virus.

I want to say that I believe we should prepare our patients' systems for vaccination, if we could have the time, as we would for a surgical operation or anything else, and I would most strongly reiterate what Dr. McDowell has said in reference to the preparation of the locality for the administration of the virus. I had a case (referring to the matter of preparing the system), a child whom I

delivered and afterwards attended that child all the way up to her maturity. Every disease that she had in which there could be any manifestation of indwelling trouble, such as syphilis or tubercular condition, whatever it might be, would have that manifestation. When she was taken down with diphtheria it took on a malignant type. Scarlet fever the same. I vaccinated her, knowing the dangers; went to the health board to secure the virus, allowed her father to see the whole process, and vaccinated her on the leg. The most dangerous attack of erysipelas set in. I remember the doctor's bill for the vaccination amounted to $60, for my attendance, before she was rid of the trouble caused by the vaccination, but not due to what I introduced from the ivory point. I wish to make this point simply, that in this case, as in my case, the trouble was not due to the Doctor's introducing poison with the vaccination, but to the untoward condition of the system, which took advantage of what he had done.

THE VALUE OF LEUCOCYTE COUNTS IN SURGICAL CASES.

WARREN C. DALY, M. D.,
ROCHESTER, N. Y.

Of what use are leucocyte counts to the surgeon? This question would probably bring a variety of answers to-day, but I believe that in a few years the degree of leucocytosis and the differential count will be quite indispensable to the surgeon. At present many regard the leucocyte count as unnecessary and unreliable, or else ignore it entirely; others, however, have a count made in every case in which there is any doubt as to the diagnosis and where such a count is possible.

What, then, does the leucocyte count show that makes it of value? First: The numerical count shows the presence or absence of acute inflammation; the presence or absence of pus; and last, but of the greatest importance, the resistance of the patient to the infection. Second: The differential count indicates the amount of toxin absorption. Thus, with these two factors indicating the degree of toxæmia and the degree of resistance in a given case we have valuable data, both for diagnosis and prognosis.

A count of 10-12,000 usually indicates acute inflammation. If repeated counts show a steady increase to 15,000 or above, pus formation is imminent if not already accomplished. A high count means not only acute infection, but also good resistance, and it is noticeable that in severe infections the cases with high leucocyte

counts show the largest percentage of recoveries. It is true that in some severe suppurative conditions such as septic peritonitis, the leucocytes may be decreased instead of increased. Yet this decrease, if interpreted in the light of the other symptoms, should lead no one astray. The numerical count, as we have said, indicates the resistance to infection, and this failure to increase on the part of the leucocytes shows the infection to be so overwhelming that the protective forces are entirely overcome.

In just such overwhelming infections the temperature is often sub-normal, and yet no surgeon would discard the thermometer altogether because it does not always register above normal in critical cases.

As the normal leucocyte count varies between 5,000 and 8,000, it is important to make repeated counts as the steady increase or decrease is of much more value than a single count compared to an arbitrary normal. We take the temperature every six or twelve hours, and to determine whether an infection is progressing or subsiding, the leucocyte count is of equal or greater value.

In cases with symptoms of appendicitis which have normal pulse and temperature, if the leucocyte count be 8,000 or less, and a second count six or twelve hours later shows no increase, I think it is a fair conclusion that the case is not one which demands immediate interference. On the other hand, if the temperature be subnormal and pulse rapid and wiry, a low count or even a normal count would not only be reassuring, but would strongly suggest septic peritonitis and a bad prognosis, just as surely as a high count might indicate a localized abscess.

In a disease so notoriously treacherous as appendicitis, surely no one will neglect any measure which offers the slightest chance of making the diagnosis more certain and making it earlier, and this assistance the leucocyte count does most assuredly afford.

In over 100 counts made by me at the Rochester Homeopathic Hospital in cases where the diagnosis has been afterwards confirmed by operation the leucocyte count has almost never failed to indicate with a fair degree of accuracy, diffuse inflammation, suppuration or peritonitis. I have found a count of 10,000 to 12,000 to indicate a rather severe inflammation of the appendix with thickening of the walls, and perhaps a few drops of purulent fluid in the lumen.

A count of from 12,000 to 15,000 in appendicitis indicates a severe and possibly gangrenous inflammation of the appendix usually with some exudate of plastic lymph, showing that the micro-organisms of infection have worked their way through the gut and reached the peritoneal surface. A count above 15,000, except in pneumonia and some of the other infectious diseases, means almost certainly, pus somewhere. If the pus be well circumscribed, the count will not be so high as in cases where it is not circumscribed, and in many suppurations the count will exceed 20,000. The higher the count the more certain the diagnosis of pus.

In the following cases of appendicitis the leucocyte counts were made before operation, and the pathological condition which caused the leucocytosis observed at operation.

1. Appendix strictured, thickened and acutely inflamed. T. 100°. Leucocyte count 11,700. Recovered.

2. Appendix twisted upon itself, adherent to intestines, acutely inflamed. T. 99°. Leucocyte count 9,800. Recovered.

3. Appendix thickened, acutely inflamed and covered with plastic lymph. No pus outside the lumen. T. 99°. Leucocyte count 12,125.

4. Gangrenous appendix, beginning general peritonitis. T. 95 3-5°. Leucocyte count 14,740. Fatal.

5. Gangrenous appendix with a great deal of plastic lymph and free pus in peritoneal cavity. T. 99 4-5°. Leucocyte count 21,330. Recovered.

This case was apparently as severe as the previous one, but having a higher degree of resistance, he pulled through.

6. Appendix gangrenous and sloughing. Much pus, but localized. T. 99°. Leucocytes 21,330. Recovered.

7. Appendix perforated and partially gangrenous. Much plastic lymph on adjacent intestines and some free pus in peritoneal cavity. T. 100°. Leucocytes 12,200. Died. This case also shows the poor resistance which may be expected when the leucocytes are not at least 16,000 in a case of such severe infection as this was shown to be.

8. Localized abscess around appendix. T. 102°. Leucocytes 24,700. Recovered.

9. Gangrenous appendicitis with perforation. Gave up work only 24 hours before operation. Abdomen filled with bloody purulent fluid. T. 96° Leucocytes 1,260. Died 12 hours after operation.

These cases, taken at random from counts that I have made, show most conclusively the factor of resistance indicated by the leucocytes. Every case here cited with a leucocyte count above 20,000 recovered, and many of these were as serious, to judge from the appearance of the appendix and peritoneum as those which succumbed. On the other hand, none of the fatal cases had counts above 15,000, whereas the local lesions would have led one to expect a much higher count. Temperature tends to parallel leucocytosis roughly; that is, the cases with high leucocytosis all showed more temperature than those with lower counts and two of the fatal cases had subnormal temperature with only moderate leucocytosis.

The last case with T. 96° and leucocytes only 1,280, was the most severe and rapid appendix infection I have ever observed, and it well illustrates both the failure of the leucocytes to respond to such an overwhelming invasion, and the grave prognostic import of such failure.

The differential leucocyte count consists in counting at least 500 cells in the stained specimen, classifying them and figuring the per-

centage of each variety. Comparison of the percentages thus obtained with the normal percentages is a valuable diagnostic aid, especially in septic or suppurative conditions.

The normal proportions of the various leucocytes are approximately: Polynuclears, 70 per cent.; lymphocytes, 26 per cent.; eosinophiles, 3 per cent.; mast cells, 1 per cent., or less. In the differential count the behavior of the polynuclears and the eosinophiles is of the most interest.

Polynuclear leucocytosis means toxin absorption, and the more severe the toxæmia the higher the polynuclear percentage, these cells rising to 95 per cent., or even more, in severe infections. With this high percentage, large numbers of them may be seen in process of dissolution, showing the destructive effect of the bacterial toxines in the blood and perhaps in a measure explaining the phenomenon of leucocytosis as being an over-production to compensate for the increased destruction of these cells.

A relative polynuclear percentage of not over 70 per cent. practically excludes the possibility of the presence of pus in any given case. Similarly, a relative polynuclear leucocytosis of 90 per cent., with a numerical count 15,000 or over, makes a diagnosis of pus almost certain in any surgical case.

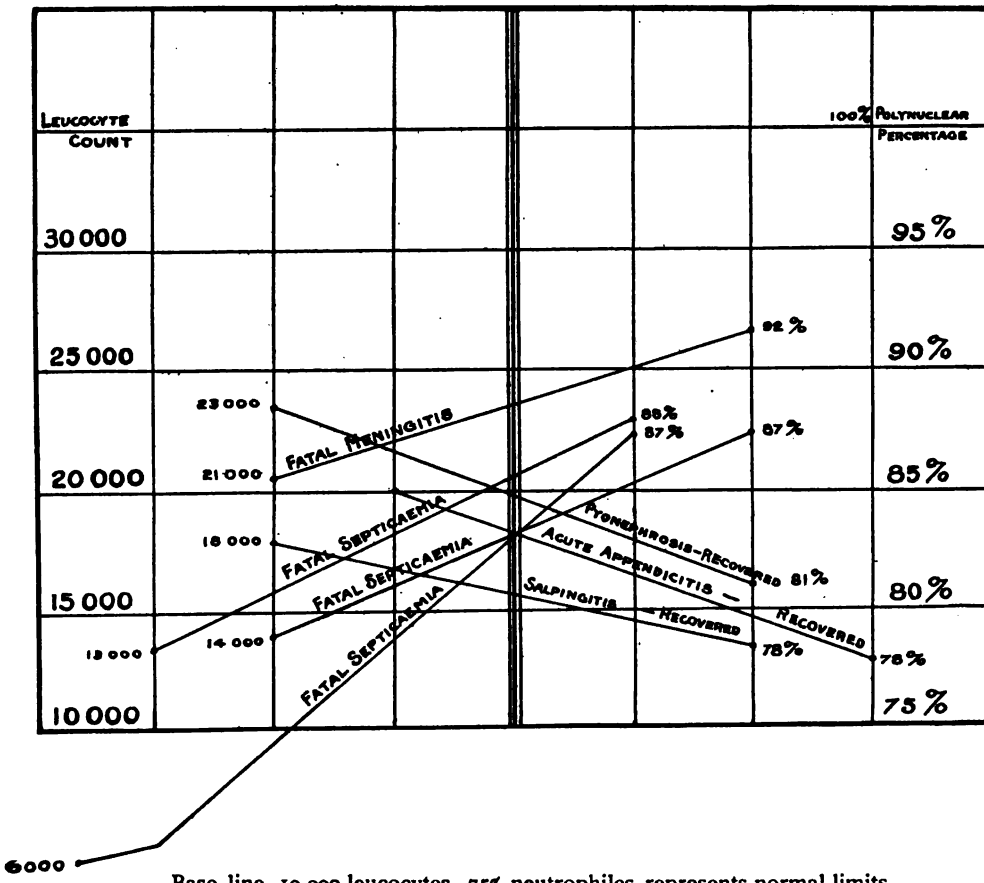
In any septic process with much toxin absorption, the eosinophiles will be relatively decreased as the polynuclears are relatively increased. The eosinophiles were absent altogether in so many severe infections that it was thought that their absence was a positive indication of sepsis. I have not found this to hold good in all cases, as I have been able to demonstrate the eosinophiles in cases of septicæmia, in which the diagnosis was confirmed by blood cultures of the streptococcus. However, the fact of a marked diminution of the eosinophiles in septic conditions is, I think, indisputable. The absence of these cells is a strong indication of sepsis, but their presence in reduced numbers does not positively rule sepsis out of the question. The reappearance of the eosinophiles after having been absent is a very favorable sign for recovery.

In any case, then, in which the leucocytosis fails, the differential count becomes of great value because even if the index of resistance fails to rise, the index of toxin absorption, or the relative polynuclear leucocytosis will still be present if the case be a septic one. Or if the numerical count be normal, and the differential count normal also, the case may, in practically every instance, be considered as without serious import, in so far as infection is concerned.

In its early stages typhoid fever presents many symptoms which may lead to a diagnosis of appendicitis, but here the leucocyte count is of great differential value. In appendicitis as I have shown, the count is invariably increased, while in typhoid fever the count is usually less than normal, ranging from 4,000 to 6,000. The differential count also shows a high polynuclear percentage in appendicitis, while in typhoid the mononuclear elements are relatively increased.

In septicæmia the leucocytosis is not very high, usually about 15,000 and often lower. As the disease progresses to its usual fatal ending, the count decreases as the resistant forces are overcome. The hæmoglobin and the red cells also show a marked decrease, owing to the hemolytic action of the streptococci.

GIBSON'S CHART.



Base line, 10,000 leucocytes, 75% neutrophiles represents normal limits. Relatively greater increase in total leucocytes than in polynuclears indicates resistance greater than toxæmia, good prognosis. Relatively greater increase in polynuclear percentage than in total leucocytes indicates toxæmia greater than resistance, and hence, bad prognosis.

These few cases well illustrate what will be found to generally hold good, that a line rising from left to right means unfavorable prognosis, while a line slanting down from left to right means a favorable prognosis.

In a fatal case of septicæmia which I recently observed, the leucocytes were only 6,300 on the third day of the fever, and gradually decreased to 4,000, thus showing very poor resistance. The differential count was: Polynuclears, 87 per cent.; lymphocytes 12.5 per

cent.; eosinophiles, 5 per cent. One week later, polynuclears, 89 per cent.; lymphocytes, 11 per cent.; eosinophiles, 0 per cent. Death occurred a few days later.

This case well illustrates the grave import of a low leucocyte count, as indicating poor resistance to the infection, and of a high relative polynuclear count as indicating much toxin absorption.

To show the relation of these two factors, resistance and toxæmia, and their bearing in diagnosis and prognosis, Gibson has devised a chart of considerable value. A copy of this chart with some of my cases on it I will ask you to hand around.

In conclusion, I believe leucocyte counts to be of decided value to the surgeon both in diagnosis and prognosis, but they should always be interpreted in the light of all the other clinical findings, and not as an isolated and infallible sign. The numerical count alone is of great value, and can be so easily and quickly made that it should be much more widely used. I have found that the normal limits of the numerical count, 7,000 to 10,000, as given by some authors, are too high, and that in my work 5,000 to 8,000 would be a better normal average. Surely, a count of 10,000 should always be considered an indication of an inflammatory process somewhere.

The numerical count, indicating resistance to infection, and the differential count, indicating the degree of toxæmia, certainly give the surgeon knowledge which can be had in no other way, and in these two factors, studied in relation to each other and to all the clinical findings, we have a very material help in the diagnosis of the most perplexing case. And as the years of painstaking study add more and more to our knowledge of the blood, the blood chart may rise to a place of importance quite equal to that of pulse and temperature.

DISCUSSION.

LUCIUS L. BUTTON: In the discussion of this paper of Dr. Daly's on "The Value of Leucocyte Count in Surgical Cases," I may say at the start that I believe, as does Dr. Daly, that, properly used and carefully considered in association with the clinical features presented by the case, it is of very great value. By means of this leucocyte count, especially with the differential count, we are able frequently to foretell the development of symptoms ten or twelve hours or more before we would otherwise be able to do so. As a result of this forewarning, we are able to forearm ourselves, and by anticipating the full development of serious conditions we are able to attack the case before it has developed into one of greater seriousness. This, obviously, is of great advantage, for we well know it is much easier to stop the progress of a disease before it has gained much momentum, so to speak, than it is in a later stage, where the invading forces are more powerful and aggressive.

In all of this leucocyte count work, though, we must not forget

that there are conditions of physiological leucocytosis. Forgetting this, we may be misled. It is well to remember that a condition of leucocytosis is produced in pregnancy, in the new born, in a post-partum state, after violent exercise and cold baths, and even a meal very rich in proteids. Starvation lowers the leucocyte count.

In primiparæ during the latter months there is a moderate increase of all leucocytes; there being, according to Cabot, an average of about thirteen thousand. In multiperæ it occurs in only about fifty per cent. of the cases.

Another thing to be considered is, that the normal percentage of the polynuclear cells varies according to the age of the patient somewhat. Dr. Daly has given the percentage as approximately seventy in normal conditions, but in infancy the normal percentage is from twenty-eight to forty per cent. Leucocytosis also is found in the moribund state very frequently, even where there is no suppuration or need for operative measures. It seems to be analogous to the terminal rise of temperature seen at the close of many chronic non-febrile affections.

It is inevitable that with so many conditions causing a leucocytosis, perplexity and doubt as to the value of a leucocyte count must arise in the minds of many who have not made this subject a special study; but to the man who has done much of this sort of work, out of what appears to be confusion, it is possible, by associating the leucocyte findings and the clinical symptoms, to make a very useful and reliable diagnosis and prognosis even in the most troublesome cases.

It seems to me in this work that the secret of success in obtaining its full value lies in the frequent repetition of the differential leucocyte count. By this means, you may be able to determine very accurately whether a patient's resistance is increasing or decreasing; whether the absorption of toxins is lessened or increased, and the rate of progress of each of these. Knowing these facts you can, by also considering the clinical evidences, form an accurate estimate as to what may be expected in the case. Knowing, then, the probabilities of the case, you may more directly apply whatever remedies for treatment seem to you to be best indicated.

POPULAR ERRORS REGARDING NEPHROPTOSIS.

SIDNEY F. WILCOX, M. D.,
NEW YORK CITY.

Occasionally, the medical profession, under the banner of conservatism and entrenched behind an accepted opinion, fights stubbornly in defense of an error which has nothing but persistent reit-

eration to recommend it. The erroneous opinion usually emanates from some popular writer, and, having been copied from one work to another, assumes a Gibraltean impregnability. The assertion may be a complete fallacy, or it may contain a small proportion of truth, but nevertheless, it is accepted for a while as a whole truth. Fortunately, the profession usually finds out its mistake and sets itself right in time. At present, however, it has not reached a full appreciation of some of the errors which are popularly believed to be truths. Nothing more clearly exemplifies this peculiar condition of the medical mind than its common attitude towards nephroptosis, and its reluctance to admit the extent to which this condition contributes to the fund of human misery.

The popular errors regarding nephroptosis, which I propose to consider, may not be pure errors. Like masses of mud held together by network of fibres, they contain a sufficient percentage of truth to give them plausibility. For that reason, I have designated them as ninety per cent. errors, and will state them as follows:

The first popular error I refer to is that, while nephroptosis *in some cases* may be productive of unpleasant symptoms, in the majority of cases gives little or no trouble.

The second popular error is that in cases where dire reflex symptoms are produced by movable kidney, they can easily be obviated by the use of various arrangements of corsets, bands, belts or trusses, or if these are not enough, the patient can be cured if she will take tonics and rest, improve the general health and grow fat.

The third popular error is that the fat will act as a natural pad, and by its pressure hold the kidney in place.

The fourth popular error is that the improvement, after an operation for fixation of the kidney, is only transient.

The fifth popular error is that the greater proportion of cases occur in women who have borne children.

The reasons which have contributed to the promulgation and fostering of these errors are:

First, a lack of appreciation of the grave symptoms arising from movable kidney.

Second, consequent neglect to examine for this condition.

Third, lack of sufficient skill on the part of many examiners to find the movable kidney.

Fourth, seeing the results of badly performed operations, or failing to recognize the fact that some patients have been ill for so long a time that the *habit-illness* is almost irradicable, although they are physically better.

For many years I accepted some of the above errors for truths, but an unusually large experience with this condition has compelled me to reverse my position to a considerable extent, and also to condemn some of these assertions as the variest bosh.

The assertion that movable kidney gives little or no trouble in the majority of cases is disproved by the very fact that the condition

is discovered at all. A patient does not generally undergo a searching examination without a reason, and the reason is that she does not feel well; and it is quite as credible to assume that the symptoms from which she seeks relief arise from the movable kidney, if one is present, as from some gynæcological condition, for which she undergoes treatment and even operation. In a considerable proportion of cases, movable kidney is accompanied by some uterine displacement, and both conditions enter into the production of the symptoms. To say that the patient suffers from "nervous indigestion," the cure of which will relieve the kidney symptoms, shows that the sayer is unacquainted with the fact that "indigestion" is largely a symptom, and not a disease in itself. The same may be said regarding the headaches, the backache, the weariness, the palpitation, the dysmenorrhœa, the bladder symptoms, the simulated attacks of appendicitis and the endless number of hysterical and nervous symptoms; because these symptoms are purely reflex, and do not constitute in themselves a distinct disease. The wearing of any of the various forms of retentive apparatus is accompanied with the greatest amount of annoyance to the patient. In order to have any form of apparatus effective it must be worn tight, and so arranged that its pressure is exerted upward and backward. This pressure must be applied principally below the lower margin of the ribs, and for this purpose, pads of greater or less thickness are required to be worn underneath the band or corset. In some very thin women the pads may be attached to a stiff spring, going around the body, like a truss. Gallant advocated a corset so arranged that abdominal pressure was made by a certain adjustment of the steels while the pads were applied to the back. A great deal of ingenuity and thought have been expended on various arrangements of corsets. Bands of all sorts have been invented and tried, from a simple surcingle of non-elastic webbing, to carefully adjusted bands of elastic fabric. Some of these are wide, some narrow, some are high in the back, some low on the hips; some are held down with perineal straps, and some with stocking supporters; but to be efficient, the pad must always be worn with it, and the pad is very objectionable to most women. It causes a great deal of discomfort by its presence and pressure, and is a source of great annoyance because it gives the appearance of the enlargement of the abdomen, to which most women decidedly object. The great tendency of the band to ride up on the hips necessitates either the use of the perineal straps or the attachment to the stockings. The perineal straps are objectionable because they must be covered with rubber, and they chafe and are very uncomfortable. The stocking supporters are less objectionable, but not generally as effective. One lady told me that she wore six pairs at a time. Another thing, a stocking supporter is only effective when a patient is standing. When the thigh is flexed, all the traction is lost. The notion that a collection of abdominal fat prevents the descent of the kidney, is erroneous;

in fact, I have had quite as much trouble with fat women who have movable kidneys as with thin ones. One lady who is well padded with fat, suffers very frequently from attacks of frightful pain from a twisting of the pedicle. The pain simulates that of gall stone colic, but never at any time has there been any corroborative symptom as finding the stones, jaundice or pain under the right shoulder blade to bear out the gall stone diagnosis. It must be borne in mind that the movable kidney slips freely up and down in a loose sheath back of the peritoneum, so that the fatter the patient the more difficult it is to make sufficient squeezing compression to prevent the nephroptosis. The truth of the idea that patients under rest tonics, etc., become permanently cured, is contrary to my observation. Some of them are likely to improve for a time while they are keeping up the treatment, but they almost invariably relapse soon after its cessation or leaving the sanitarium. On the other hand, this form of treatment is expensive, and only those who are able to afford the luxury can carry it out. Also, many patients do not respond to this form of treatment to any extent, for the reason that the cause is not removed.

The idea that nephroptosis occurs more frequently in women who have borne children than those who have not, is also misleading. In one hundred and seven patients which constitute an incomplete list of my operated cases, fifty-seven of the patients were unmarried, and yet a number of them suffered from bilateral nephroptosis; also twenty-eight of these patients were operated on for retroversions, ten for appendicitis, one for stone in the kidney and one for hydronephrotosis.

During the past few years the professional mind has been so strongly imbued with the idea that right iliac pain always results from appendicitis, that many mistaken diagnoses have been made and many appendices have been removed without benefit to the patient, whose symptoms arose from movable kidney. Personal experience confirms me in this belief.

The statements made in this brief article are based on observation of several hundred cases, and are, I believe, correct. Formerly, I advised all patients to try palliative measures, and even now I have a number of patients who prefer not to have an operation under this treatment, but I have met with so much disappointment in the results that it seems to me foolish to recommend, especially to young patients, methods of treatment that can never be curative.

That patients relapse as a rule after the operation of nephropexy, is contrary to my experience. Some cases may relapse, but I believe the proportion of cures where the operation has been properly performed, is as high, or higher than after the operation for any other surgical condition. Often, the recovery of health is slow, and in fact, I believe that many patients recovered without realizing it. They have been so long in the habit of feeling ill that they are apprehensive and are constantly expecting unpleasant symptoms, and fre-

quently they recover their health without knowing it; and it is only through the powerful suggestive influence of some strong mentality that they are convinced that they have recovered. These are the cases which form some of the so-claimed brilliant cures which are ascribed to the Christian Science healers. In bad cases it is unreasonable to expect the full good result of the operation for at least a year or two after its performance. Illustrating this point, I wish to quote from a letter received from a lady in a distant city within the last three weeks. I quote from this letter because it is the last one I have received, but it is typical of many which I have in my possession.

"September 4, 1907.

"*Dear Doctor Wilcox:*

It has been on my mind for some time to write and tell you how well my daughter is. She is like an entirely different person in every way; bright and happy all the day long, and enjoying everything that young people should enjoy. I feel that I have at last found my daughter and cannot be grateful enough to you for all you did. The other day for the first time I heard my husband say, 'That money was well spent,' and I can't say that he thought so until now. * * * For the first time since she was thirteen years old has my daughter really enjoyed people."

This patient was operated on about eighteen months ago, and is typical of one class of cases which comes to us frequently for help. In a family where no expense was spared, with a mother who is sensible and not sentimental, and who has done everything to further the pleasure and well-being of her daughter, this young lady was in miserable health, and in spite of rest, tonics, and medicines, was steadily drifting into a state of chronic invalidism. It is easily seen from the mother's letter what has been the result of nephropexy and Alexander's operation.

I wish to cite only one other case as typical of another class. It is that of a young lady brought to me by Dr. Wm. H. Diehl, of Brooklyn. She had been under treatment by various physicians for two or three years for disease of the knee joint. She came to my office on crutches. On examination, there was no swelling, but I observed that she kept the knee constantly in the extended position. This, with other signs, made me think of hysterical knee, and on making a thorough examination I discovered a movable kidney. I assured her that the knee was quite curable, but to restore her to complete health the kidney would have to be fixed also. Of course, I did not reveal to her my opinion regarding the knee. A few days later I fixed the kidney, and made a few light strokes with the cautery over the joint, just sufficient to redden the skin. In three days the joint was quite movable. She spent the usual time in the hospital for convalescence from the nephropexy, and has been quite well since.

It may be claimed that the suggestive effect of the use of the cautery and the assurance that she would be well, effected the cure. That is partly true, but it must be remembered that all former treatment, suggestive or otherwise, had been ineffective, and it was not until something had been done to cure that enigma of medicine—the hysteria—that the result on the knee was obtained.

DISCUSSION.

WM. H. BISHOP: In reading over a synopsis of this paper which Dr. Wilcox handed me, and since then, in listening to his paper, I must admit that I am perhaps in the list of those who have entertained these popular errors. Dr. Wilcox's long experience and his enthusiasm on this subject certainly entitle him to a position which very few of us in the younger ranks should assail. His experience has been very wide, and I have always looked upon Dr. Wilcox as an authority on this subject. I think probably his ideas have been somewhat changed, and that he himself was perhaps guilty of committing some of these errors of which he now speaks, and of which we are probably all guilty at the present time. It seems, however, that his enthusiasm has carried him perhaps a little beyond the modern opinion of most men, and especially the teaching of the books, the so-called text-books. As to the question of the percentage of movable kidneys, especially in females, which of course we all know is pretty high, some books giving it as high as forty per cent., it certainly is within reason to believe that forty per cent. of the population of this town should not have operations for movable kidneys. If we did, it would be all the better for the surgeons, perhaps, and possibly better for the patients. In other words, a great many patients who have movable kidneys are not operated on and do not have symptoms. His first error is, "in the majority of these cases little or no trouble follows." That is an error. That is not given as a statement that he believes, but he believes that in the majority of cases symptoms do follow. As I say, my experience is not sufficient to entitle me to debate that question with Dr. Wilcox, and I may be amongst those who are committing the error of thinking, as with many gynæcological patients, that a misplaced uterus oftentimes will not necessarily produce symptoms. I think you all must admit that, and still a great many uteri that are out of position do produce symptoms. In other words, the case of movable kidney must be selected for operation, and not the indefinite case or every case that comes to a doctor with movable kidney should be fixed, or anchored. I am willing to admit, then, that I am one of those who are in error, and probably will look for more of these cases as producing symptoms than I have in the past.

Another popular error that he speaks of is, that if the patient will

regain her lost fat, as it were, her kidney will become anchored. I scarcely think that is a popular error. I think that very few surgeons and medical men believe that fat does act as a pad. We all know that the anatomical support of the kidney comes from other sources than fat. We have the reflex peritoneum, we have the blood vessels, and we have the fat also; but it is hardly a popular error, the belief that fat is the only support, and that if the patient will get fat, his or her kidney will be anchored. I simply take issue in that I hardly think we are in error in that; I do not think that is a popular idea.

The cases that have seemed to me the ones that yield less readily and rapidly to the treatment of nephropexy are those in which neurasthenia has been developed, and those cases in which a long train of nervous symptoms has been existing for years. In other words, the habit of illness that Dr. Wilcox speaks of, once established, even an operation of nephropexy will fail many times.

I think the paper has been a very instructive one, and that it will perhaps put many of us on the right track and help to prevent so many of our patients with floating kidneys slipping through our hands, when Dr. Wilcox gives us so much encouragement, and we will be a little more particular in the corralling of such cases.

WILLIAM W. BLACKMAN: It is not easy to discuss a paper which you entirely agree with. The paper is so well written and presented that I do not think it needs very much discussion. I presume there are a good many people who have the so-called floating kidney and are not aware of it. Neither are their physicians aware of it. It gives them, possibly, no trouble. I doubt if all the cases of misplaced kidneys give people the pain and various reflexes that are attributed to them, but there are a great many cases that do, and in those cases it is rational and proper that the organ out of place should be put back and anchored by operation. I do not believe in the various devices and bandages and pads. It is a question which of the two causes the greater inconvenience and discomfort to the patient, the pad that is worn, however well it may be made, or the kidney displacement itself. The operation will remedy it, put it in its place and keep it there. The pad will not do it. The pad is a good thing for the man who makes it. He gets a good large price for it, and it does the patient no good.

HORACE PACKARD: I do not like to assume the privilege of the floor again, but it is indeed difficult for a garrulous man to sit under such interesting papers, and not say something. I want to endorse every word of Dr. Wilcox's paper. I was a doubting Thomas in the early part of my surgical career over this subject of nephroptosis, and it was only through hard knocks that I got it driven into me that it is not always the cause of profound and long invalidism. I will report a case, very briefly, one of the most impressive—stands out as prominent almost as any case I ever had in my life.

It was a case of quite long standing, and a malady obscure;
Fourteen doctors had advised her, one and all had failed to cure.
Some said it was a delusion, colic, gall stones in the cystic duct;
Others called the patient splenic, said she imagined things, no doubt.
She in turn declared them stupid, didn't understand her case;
"Spare me! Spare me from more doctors! Let me die, but give me peace!"
Die she did not, for she could not; all her vitals were O. K.
Aching, paining, still she lived on, till the surgeon came her way.
"Well, what is it, Surgeon?" quoth she. "See you aught in me of note?"
"Patience, suffering woman, 'tis your kidney is afloat."
"Oh, horrors! He's deceived me. What is this, it is afloat?
Is it dropsy? Tell me, Surgeon, must I have my kidney out?"
"No, no; keep your kidney. It is still as good as new;
Back in place it must be fastened—only needs a stitch or two."

ELIZABETH HAMILTON MUNCIE: I am again impressed with the fact that we see what we look for, and then again, how that law of life is ever active in nature, as well as in the therapy which we preach; and so Dr. Wilcox and others attract to themselves those cases that are floating by with floating kidneys, and they look at those cases. Now, I do not mean to say that in looking for that they see what does not exist, because they see that that does exist. So we could go through with each specialty. Now, I am accused, as Dr. Wilcox has been accused, for several years, off and on, by certain conservatives, of only seeing one thing along certain lines. Many of you know what I have been accused of. Now, it is a fact that I am looking for reflexes from pelvic disturbances, and I see them. Therefore, when a case presents itself to me with floating kidney, possibly I am capable of diagnosing a floating kidney, possibly not—I am not sure of my diagnosis, I will tell you that, and I am always glad to send such cases to Dr. Wilcox—but what do I do first? Why, I say, "Yes, my dear lady, I find a floating kidney here, the same as Dr. Janeway and others have said; that is, something that seems just like a floating kidney; but I also find here an adhesion of the uterus, enlarged granular casts, very irritable vagina; I find a retroflexed uterus, and I find scar tissue extending away up the body of the uterus, and in the rectum I find pathologies, and here I find, at the sigmoid, a prolapsus." And as I use my sigmoidoscope, with electric light, perhaps passing seventeen inches, I see little particles of fecal matter adherent here and there to the mucous membrane; and I say, "Let me first correct all these conditions, and wait from six months to two years, and if these symptoms with which you are suffering shall be improving all the time, possibly that kidney will not stray out of its position any more. Then, if it does, why, we can send you to Dr. Janeway." Perhaps they have been to Dr. Janeway, and I am under obligations to send them to

him. I send them to my own school if I can; send them, perhaps, to Dr. Wilcox, but I advise them to wait six months or so, and see; and, do you know, in almost every one of those cases, Dr. Wilcox and Dr. Janeway are cheated out of that last operation. Now, that is simply my standpoint in the matter. But very, very often the case does not become relieved of the very last symptoms. If I have time, may I just give one case in illustration?

A certain woman came in to my office who had been in Boston. She was pulling her hair out, almost, with pain, and she said, "I have had six operations; I have had everything removed, even to one kidney; and now, they say it is only hysteria. Can you do anything for me?" I found a prolapsed sigmoid. In half an hour after the replacing of that sigmoid, every symptom had disappeared, and the woman has been perfectly well for five years. So my motto is, in relation to this dreaded floating kidney—get all the other conditions of pathology out of the way and let the kidney do the best it will; and then get rid of the kidney, or patch it up.

SIDNEY F. WILCOX: There is not much to say in closing the discussion, because the paper has been very kindly and favorably received. I only want to say one thing, Mr. President; that is, that I have always had a great fear of being a "crank," and so I have made it a rule, in examining every case, to always examine every part of the patient before I examine the kidneys, and that is the last thing I look at.

HYOSCIN, MORPHIN AND CACTIN ANÆSTHESIA.

CHARLES E. WALTON, A. M., M. D.,
CINCINNATI, OHIO.

The surgical trinity is Paré-Morton-Lister. Whoever wields the knife, worships at the shrine upon which is engraved—Ligature—Anæsthesia—Antisepsis. In their name he works his wonders. Without them his work would be primitive, his results uncertain, knowing nothing of bloodless, painless, pusless surgery. With them he has the "open sesame" before which the very citadels of life capitulate. Their function renders them essential. Any improvement by which their function is enhanced, is of paramount importance.

To-day let us consider a comparatively new anæsthetic. Ether and chloroform have become the most widely known and most universally used agents for preventing pain, but occasionally they produce "a sleep that knows no waking." Valuable local anæsthetics have been discovered to modify their use, but many operations demand a general anæsthetic. The latest agent which is now

a candidate for surgical acceptance is the Hyoscine-Morphine-Cactin tablet, administered hypodermically. The tablet is composed of chemically pure Hyoscine Hydrobromide 1-100 grain; chemically pure Morphine Hydrobromide 1-4 grain; Cactin (from Cactus Grandiflorus) 1-67 grain.

This paper is not written for those who never give morphine under any circumstances; they do not use the knife. Nor for those who have a fit at the mention of a combination tablet: this is not a homeopathic prescription. It is written for the operating surgeon and the humane obstetrician, who is not biased by the declaration, "In pain thou shalt bring forth children."

It is of prime importance to consider the first ingredient of the tablet. The Hyoscine *must be* chemically pure, and procured from Henbane (Hyoscyamus niger). It *must not* be Scopolamine, an alkaloid from a different source, and of different therapeutic value. The deaths reported from some quarters have been due to the use of the latter alkaloid. No fatalities, I believe, have been reported from the use of the tablet made by the Abott Alkaloidal Co. Dr. Emery Lamphear, of St. Louis, reports its use in 400 capital operations without an accident or unpleasant symptom, and he has reports of more than 1,000 cases in which it was used by others with similar results. Stimulated by Dr. Lamphear's report, I have used it lately in the following cases:

Case 1.—Abdominal section. Removed a dermoid cyst of left ovary, and a unilocular cyst of right ovary. Gave first injection two hours before operation; the second, one-half hour before operation. Patient came to table sleeping quietly, and incision was made without flinching or any indication of pain. During the operation some twenty or thirty drops of chloroform were given for the benefit of the family physician, the patient making an occasional groan. Patient slept most of the afternoon, and had a comfortable night. Recovery uneventful, no vomiting no medication, no recollection of operation.

Case 2.—Section for large ovarian cyst. Two tablets as before. Painless incision, some groaning while breaking down adhesions high up in abdominal wall. No chloroform, quiet day and night, no medication, no recollection. Ideal recovery.

Case 3.—Double herniotomy. Patient 70 years old. Large epiplocele of 40 years' standing on one side; small enterocele on the other side. Two tablets. No chloroform, no pain, no vomiting, no complications.

Case 4.—Abdominal section. Amputation of part of omentum and breaking up of extensive pelvic adhesions. Two tablets, no chloroform, no pain, slight nausea, uneventful recovery.

These cases constitute the extent of my experience with H. M. C. The results certainly warrant a continued use. Its advantages are: No antipathy of patient, no dread of chloroform or ether, so frequently met. No nausea, as a rule; no post-operative pain, no con-

stipation, on cyanosis, no shock. It seems to be an ideal anæsthetic.

During the operation the heart beats run up to 100. but are full and regular. The respiration slows down, as in profound sleep. The face gets red. The pupils are responsive to light. The desire for water after the operation does not begin so soon, and can be gratified.

For convenience of dosage, one-half strength tablets are made. Thus, full doses or half doses can be given, according to the effect desired.

In obstetric cases the patient can be given a painless delivery without danger to the child. In gall-stone colic, and similar pain, one tablet will do the work of three ordinary one-quarter doses of morphine. In alcoholics it furnishes a reliable hypnotic. In emergency surgical cases it puts the patient in a comfortable condition to wait for operative relief.

An extended experience with this tablet will relegate the Atrophine-Morphine tablet to the company of the medicinal "has beens."

My knowledge of this anæsthetic, aside from my experience in the cases mentioned, has been secured from a pamphlet written by Dr. Lamphear. I feel that we have in this agent an important addition to the equipment of the physician. The desire to extend its usefulness is my excuse for occupying the time of this Bureau.

DISCUSSION.

T. DRYSDALE BUCHANAN: For a long time I have been familiar with the scopolamin-morphin anæsthesia, and the great number of deaths which were reported from this form of anæsthesia naturally made me rather timid about taking up the hyoscin-morphin anæsthesia and the cactin. However, we used it in one case at the Flower Hospital in which three tablets were given, starting two and a half hours, one and a half and half an hour before operation. The operation was a clamp cautery for hemorrhoids, which is a very severe test of the anæsthetic properties of any drug. This man's respirations, about fifteen minutes before he went into the operating room, went down to five; his pulse went up to 200, and he looked badly. I went to get a hypodermic of adrenalin, and by the time I had secured that the pulse was better and respirations slightly better, without any treatment at all. He was put on the table, and the minute his rectum was dilated he made some remarks: he told me that I would never get him in that position again. He slept for twelve hours after the operation, awakened without any nausea or vomiting. On asking him if he remembered anything, he said no, that the only thing he felt were the stitches that were put in his rectum. As we didn't put any stitches in his rectum, he was wrong in that, but he evidently felt a little something. No chloroform was given. The respirations going down to five, and the pulse going up

so high, did not encourage me in using the hyoscin-morphin-cactin any further, until Dr. Bukk Carleton took it up at the Metropolitan Hospital on Blackwell's Island. Now, at the Metropolitan Hospital we have a type of case that is very difficult. Anybody that can anæsthetize one of those fellows, can anæsthetize anything on earth. They are fellows that are exposed to the air; they are poorly fed, and they live mostly on rum. They are typical alcoholics. We have forty-three cases over there in which the H. M. C. tablet was given an hour and a half, and a half hour before operation, and I must say it has made a great big change in the institution over there. We can take a novice, possibly starting in on his first anæsthetic service, and he gets his patient under very quickly. We use it there as an auxiliary, not for complete anæsthesia. The amount of chloroform has been reduced greatly. I have heard of this thirty drops of chloroform, and I have read of it, but for the alcoholic case at the Metropolitan Hospital thirty drops of chloroform are no good, and sixty drops are no good. We had one fellow who had taken quite a little chloroform, I have forgotten just the exact amount, and the minute the first incision was made he raised himself right off the table. I had one case week before last in which the interne was giving the anæsthetic, and had given at least a dram, if not more, and when Dr. Carleton made the incision he squirmed all over the table, so that we had to give more chloroform. However, it has cut down the amount of chloroform used, and it has cut down the great nausea and vomiting.

Of the forty-three cases I have mentioned, nine have vomited, seven of those from having been given water right after the recovery from the anæsthesia, and two for no reason at all; that is, they had not received any food or been given any water, or anything of that sort—seemed to be no excuse for the vomiting in those two cases.

I had a case the other day for Dr. Carleton—an old man eighty-two years of age—in which I gave two tablets. He was on the table twenty-five minutes. He received a dram and a half of chloroform. An enlarged prostate was removed by the suprapublic route. We had every reason to expect shock. The old gentleman awoke entirely free from nausea; no vomiting and absolutely no shock, and there has been no shock up to date.

Now, as to the disadvantages of this thing—Dr. Walton says the pupils are responsive to light. I have not found the pupils responsive to light in any of these cases. The pupils are contracted down to a pin point. We must be sure of our hyoscin— and, by the way, the Journal of the American Medical Association still claims that hyoscin and scopolamin are one and the same drug; and the fact that the pupil reflexes are lost, deprives you of a valuable aid in knowing how far under the anæsthetic the patient is. But I think that up to date we must say it is some advantage and some advance in anæsthesia, especially with alcoholics. The Abbott people claim

for their tablet that it does not retard labor, but I am told by Dr. Fitzpatrick, of Chicago, who does a large obstetrical practice, that unquestionably it does; and Dr. Costain, an anæsthetist of Chicago, substantiates his statement. Dr. Costain said it absolutely stopped the pains of labor, so that in using it now he gives twenty grains of quinine to help them along.

Another objection to the hyoscin-morphin-cactin anæsthesia is the rigid abdominal wall; they have to give some chloroform to get this relaxation. I do not believe that the returns on the thing are all in yet, either. There may be some patients that are peculiarly susceptible to hyoscin, and peculiarly susceptible to morphin, and we may run across some of those cases some day. We may get thousands and thousands of anæsthesias without having trouble, and then we may strike one of these patients that is susceptible.

As to the water—most of the patients do complain of an extreme dryness of the mouth on awaking, so that they have to have some water right away.

DEWITT G. WILCOX: About a year and a half ago I began using scopolamin with morphin as a preliminary to the general anæsthetic. I used it in about seventy-five cases, with very satisfactory results, indeed. In fact, I had no bad results. But there was so much said in the journals at that time in regard to the dangers of scopolamin, that I became a little frightened and discontinued it. While using it I found these effects: In giving two doses, 1-100 scopolamin and 1-8 morphin, prior to giving chloroform, an hour or perhaps thirty minutes before operation, the patient in almost every instance was asleep when we were ready to give the anæsthetic, to such an extent that afterward they did not recall the taking of the anæsthetic at all. We were also enabled to give very much less chloroform than we had been giving for the same operation theretofore—I should say perhaps one-half or one-third less. We found also that patients came out from the anæsthetic—and I am speaking now of chloroform—very much more readily, perhaps in half the time. We found they had very much less nausea and vomiting, and much less thirst, all of which made it extremely satisfactory. In only two cases did I attempt to operate without an additional anæsthetic. One was an ordinary curettage, where the patient objected seriously to taking the anæsthetic, as she had taken it before and behaved badly. In that case I gave the two usual injections, and the patient was sound asleep when I began the operation, and I carried out a very thorough curetting. She slept from eleven in the morning until two in the afternoon, and awakened without having any serious trouble. The other was a vaginal hysterectomy for cancer, where we got through equally well.

After I had ceased the use of scopolamin I missed it very much indeed, because we began having the old trouble again—the patients objecting to taking it, having so much fear of it, and the after vomiting. When my attention was called to the cactin pill I began to

use that, and have obtained about the same results that Dr. Walton mentioned, and results which I think were as satisfactory as those obtained from scopolamin. The only reason I had for using the cactin pill in place of the scopolamin was that there was so much said in the medical journals as to the dangers of the latter, and the almost positive avoidance of danger with the former.

I think, as Dr. Buchanan says, there are more returns yet to be heard on this subject, and we should go very carefully indeed, in the use of this tablet. I am not ready to say, from my limited experience with it, that it is devoid of danger, but I do think we have a very valuable aid here in the production of a general anæsthesia.

J. W. HASSLER: About a year ago I had been using the combination of scopolamin and morphin at the Metropolitan Hospital. Before attempting it I spent a couple of hours with the chemist of Merck & Co., as I had read of the action of the different drugs manufactured by the several firms. The chemist stated that the present scopolamin and hyoscin upon the market were identical. He also reported that of six different preparations which they had tested, each one varied as to strength and action. In the forty odd cases which I had before Dr. Buchanan tried his H. M. C. preparation, I will confess that I was rather fearful of the action of this drug, and I prepared a paper for the State Society at the Albany meeting two years ago on "Why Scopolamin?" At that time Dr. Bartlett reported twelve deaths. There were twenty-two deaths reported by a German observer, whose name I do not recall. Also about that time, Dr. LaPlace, of Philadelphia, who had visited France and Germany, returned with the statement that they had given it up over there, and were fearful of it. Since the H. M. C. tablet has come upon the market, I have seen but two cases, and these within the last two weeks; having been out of practice for the last seven months, I have failed to keep posted, but I happened to be in a town where this H. M. C. tablet was administered; the effect was splendid. I confess, however, that there are two principal symptoms produced on the patient by hyoscin or scopolamin that I do not see how an abdominal surgeon would like. These are, first, the rigidity of the abdominal muscles, which is persistent unless the chloroform is pushed to deep narcosis; and, second, the excessive arterial dilatation, causing excessive bleeding at the time of operation. Whether Dr. Walton has found this so, I cannot say. I may say, though, that Dr. Walton is very, very lucky in having all his cases go to sleep without the addition of chloroform. Of the forty cases I speak of, only eight or nine were able to be operated upon without the addition of chloroform, and they were minor operations. His report that there is no action upon the pupil is erroneous. The pupil in most of my cases, unless supplemented with chloroform, became dilated and did not react to light. In the alcoholic cases the conditions at times became alarming, and

in a number of my cases the respirations were four to the minute, and in none of the cases was the respiration more than fifteen to the minute, with a very rapid pulse.

ORANDO S. RITCH: At the Cumberland Street Hospital this tablet has been used by most of the operators without any untoward or deleterious effects whatever. In one case in which I used the tablet I was very glad that there was such a thing in the market. It was a case of attempted suicide, in which a man had completely severed his trachea and also the æsophagus. A hurried call of the ambulance led to the ambulance surgeon merely closing the wound in the throat temporarily, expecting the man would die by the time he got to the hospital. Unfortunately he did not. I say that with all reverence to the patient. At any rate, the man set out to live, and I was confronted by a proposition that I had not thought for. I took about four or five days before the man reacted, in which time we had to keep him alive by artificial methods of feeding. Then we came to the question of operation. My assistant gave him a tablet at twelve o'clock, another one at two o'clock, and about a quarter after two I commenced proceedings. I first had to go in back and unite the severed æsophagus, and then out through the trachea, and so on. The operation consumed something over one hour, and the man to all intents and purposes was devoid of pain from beginning to end. I think in that one case alone it was the means probably of saving the man's life, because if I had had to rely entirely upon an anæsthetic through the hole in the trachea, so much time would have been consumed, with the danger of a possible pneumonia or conditions of that kind following, that in all probability we should not have been able to save the man's life.

DR. WALTON: I am very glad for the way in which the paper has been discussed. There are two or three points I want to clear up.

It has been said that scopolamin and hyoscin are identical. They are chemically the same. They are therapeutically as diverse as products secured from entirely different articles. John Wyeth Company report that the so-called hyoscin upon the market which has less than a minus 20th rotation is an unsafe drug. The scopolamin which has received the name of hyoscin has a minus 2 rotation. So we are confronted with this proposition: Are we going to use the pure drug, the hyoscin, or the scopolamin? Cut out your scopolamin and you have gotten rid of most of the dangers. That ought to be borne in mind.

In regard to obstetric practice, just remember, when using a drug of that sort, that you are using a very powerful agent. You can put in enough chloroform to retard your birth. You can put in enough of this H. M. C. to retard your birth. What do you put in a full dose for? Put in half a dose, and wait and see. Then you can augment that later.

In regard to the pupils, sometimes they become quite dilated. I was stating the general effect when I said they responded. Sometimes they become quite dilated, and then, if you have to give another dose, give pure morphin instead of the hyoscin and cactin. My work has all been done with the two tablets, purely experimental. I thought if anybody else had done this thing, I could do it, and I tried it on these abdominal cases with favorable results. I believe we have a very fine anæsthetic, an auxiliary, if you may so look upon it, that will help us cut down our chloroform; and the less you can use of the chloroform and the ether, the more comfortable your patient will be.

SURGERY AND THE PUBLIC.

WILLIAM FRANCIS HONAN, M. D.,
NEW YORK CITY.

Medicine and surgery became established possibilities with the dawn of the human race; there is divine inspiration even for the production of anæsthesia in surgical operations at the very outset, for when the Lord desired the necessary rib for the creation of Eve, holy writ tells us that he first caused a deep sleep to fall upon Adam. The fruit of man's first sin, that of disobedience, brought upon the human race the wrath of the Omnipotent, inflicted it with sickness, sorrow and death; man to earn his sustenance by the sweat of his brow, woman to bring forth the product of conception in pain, thus making possible clinical medicine, surgery, obstetrics and remotely indicating the necessity for labor organizations. There has been a curious relationship and development between applied religion and the healing art. Since man was to be afflicted with disease, just as he was to feel hunger and thirst, the summer's heat and the winter's cold, just so became the necessity for combating bodily ailments. In the same proportion as his physical needs were to be met by sustenance and protection, the requirements of his soul hunger, the source of his idealism, became some form of religion. Nowhere in the world's history, no matter how remote the time, or nebulus the period, but man is found worshipping a divinity in some form, devoting frequently a large portion of his time and the result of his energies to the adoration of an idea or personality, all-powerful, ever-present, capable of loving, rewarding, and inflicting punishment. Mingled in more or less intimate relationship, partaking of its mystery, weaving in and out with the customs of various peoples in varying degrees, the healing art and religion have had a curious companionship. The relation-

ship of ancient times, clouded with superstition and confined by bigotry, was not without some positive knowledge, for the second Hipprocrates, the Father of Medicine, 470 B. C., became well acquainted with the medical lore of the Egyptians, which had been practised for a thousand years and included operations of many kinds and use of instruments and methods of more or less precision; yet the basic idea in the minds of the people which was responsible for these effects was a superior or supernatural power, not natural law of cause and effect. This phenomenon of ancient times has its counterpart in the present. Is modern religion, the source of comfort, the basis of ethics, the fount of idealism, failing to supply the intellectual and spiritual pabulum to the people of to-day? Is modern medicine, purged of everything that cannot be verified by the microscope, test tube, and clinical experience, cleansed of tradition and brought to the highest standard of excellence, failing in its mission to suffering humanity? If these two great institutions are not to a certain extent failing in their respective missions, how are we, then, to explain the gradual, subtle, but sure spread of a cult embodying in its proposition all that is necessary for man's spiritual and physical disorders and taking its authority from On High? Insidiously permeating every community, its sophistries are made to appeal not only to the ignorant, but more especially to the refined and best educated elements. Behind all of this, is an organization which for solidity, far-reaching purpose and discipline, is the wonder of our times, and its self-appointed, self-perpetuated reverend mother is the only source from which knowledge can come during her life or after her death. I refer to Mrs. Eddy and the doctrines of Christian Science. I speak not disrespectfully of the faith of any man, but the medical profession must recognize a powerful opponent—religion, a formidable rival. The practice of medicine has to an extent been discredited in the eyes of the public, physicians have overlooked the practical observance of a few natural laws which this cult has seized upon, and under the guise of almost divine paternalism, created a propaganda for the diffusion of the new light. The guardianship of public health by quarantine, preventive medicine, the early recognition and stamping out of epidemics, the popular teaching of hygiene—in a word, the honest efforts of the medical profession, which is practically legislating itself out of business by controlling disease, are either not recognized or are forgotten. This is a matter for the profession to consider and, if possible, combat by the proper remedy; for that performance I submit the treatment to our medical brethren.

Surgery has always been the department of medicine that has aroused public interest. It had always had its heroic side and melodramatic aspects, it is a practical, tangible thing, something that appeals to the senses, stirs the imagination and seemingly never taxed the credulity of the lay mind. To the popular mind it is method with broad sweeping movements, much blood and exciting

moments. It is the one arm of the profession that to-day maintains public confidence in the rest of it, and allows general medicine to keep its countenance and shields it from the epithets of doubt and empiricism. 'I believe in surgery, but have no faith in medicine,' is a very frequent, if hardly a just comment. The various medical fads that from time to time have been foisted upon a gullible public have not affected surgery, and Mother Eddy and her followers have, with rare wisdom and foresight, kept aloof from the subject which they knew full well would breed disaster to their cause. If, then, in this period of transmutation, surgery is to play the role of general guardian and protector, is it fulfilling the role completely at the present time? One of the delusions thoroughly fixed in the lay and occasionally in the medical mind, is that consultation with a surgeon means operation necessarily. "I might have known you would say operation," said a fair patient recently, with an extra-uterine pregnancy, "because you are a surgeon." That in earlier days, when diagnosis was, as I believe, less exact when modern surgery was to an extent in a more or less experimental stage many unnecessary operations were done. The work of Lawson Tait, though necessary at the time for the development of that day, made thousands of women lose their ovaries unnecessarily; so also various other fads, vaginal hysterectomy, for instance, performed with an amazing degree of frequency, brought just and proper censure upon us. On the other hand, the surgeon is confronted even now with the statement, "Well, I don't believe in the knife anyway," finally, as an ultimatum that no operation will be consented to unless Dr. S. approves. Dr. S., to whom modern surgery is as completely a sealed book as the bridge-whist rules of the Pharoahs, who never invoked surgical assistance except as a last resort, and as a cover to his own stupidity, has in his decision the probable fate of a human life; and the question is, how does he dare in the absence of special knowledge and experience, constitute himself the arbiter of life and death? I am glad to say this nowadays does not occur so frequently, but it has happened in my practice in this very city. The friends of the patient again err in a serious, threatening case, where danger marks delay, insisting with the greatest obstinacy that though a council of physicians and surgeons have decided upon immediate operation, consent will not be given until some parent or relative, at present far away, arrives upon the scene. Their presence cannot be of any special use, their opinion is of no earthly value, yet they have the final decision, and possibly the danger of a fatal complication is imminent upon the delay awaiting their arrival. The public expects an exact diagnosis and, more particularly, a truthful prognosis. An exploratory operation, for the purpose of making an exact diagnosis and treating conditions as found, should, but does not, appeal to the patient and friends. It nearly always indicates to the patient a woeful amount of ignorance, and particularly utter absence of that second-sight accomplishment

the physician is supposed to possess. It is not altogether ignorant (the public, I mean), it may believe that a poultice draws, that inflammation and suppuration in wounds come from getting cold in them, instead of from infection, but it may surprise you sometimes by informing you that a differential blood count will diagnosticate between typhoid fever and appendicitis. There is an amazing amount of knowledge, such as it is, in the Sunday papers and magazines on medical and surgical subjects, which is always read with great interest, and is the chief, if not the only source of lay knowledge on such subjects.

According to the best observers, typhoid perforation occurs in six per cent. of the cases, of which 37.3 per cent. die on the first day, 29.5 per cent. on the second, and 83.4 per cent. during the first week. Granted that the dangers of surgical intervention are great, one would not hesitate to open the abdomen and suture the intestines in gun shot wounds. Early operation in typhoid perforation has been successful and many lives have been saved when physicians are sufficiently alert to make an early diagnosis, and when it has sufficiently permeated the profession that this condition can be successfully treated by surgical intervention, we shall have gained much in progress of our science and art. Extra-uterine pregnancy, which was formerly seldom recognized before rupture of the sac, has been found since to occur once in every five hundred pregnancies, and its surgical relief at present constitutes between three and four per cent. of all major operations performed. Furthermore, thirty per cent. of all women over thirty-five years of age die of mammary cancer, and one in thirty-five of cancer of the uterus. The necessity for prompt recognition and speedy treatment of this dreadful condition, is obvious. In the matter of gall-stones, Schroeder and others found them in forty per cent. of male bodies subjected to post-mortem examination, and in twenty per cent. of females. As jaundice, unfortunately for its diagnostic significance, occurs in only fourteen per cent. of the cases, the lessened importance of that symptom is apparent. Jaundice occurs in only twenty per cent. of all operable conditions of liver and gall ducts. Appendicitis, mastoid disease, osteo-myelitis, and other acute infections are so rapid and disastrous in their effects, that delay in their recognition and prompt surgical treatment has brought much just censure upon our profession. The occasional apparent recovery by expectant treatment of such conditions only lulls the medical attendant into a state of fancied security in his conservatism.

To my medical friends, who have usually the first great responsibility, I would say, employ careful application of methods of diagnosis. Inspection, palpation, mensuration, percussion, and oscultation you put in daily practice, yet a physician lost his standing with a family because he prescribed for what he supposed from the patient's description was inflamed inguinal gland, when it was an inguinal hernia. Another treated a young woman for neuritis of

the foot, until some one X-Rayed the member and found a fracture of one of the small bones; another treated a patient for gout for some time without success, but finally another physician asked to see the foot, fitted some plates for flat foot, and won the undying regard of the patient. A very clever clinician treated a man for ten days, left him as convalescent, and would not see him again unless requested to do so; one of our brilliant diagnosticians saw the patient, made a blood count, knew there was pus somewhere, examined per rectum, and found a large appendicular abscess ten days old. It is not that we do not possess the proper knowledge, but we do not always take the time to apply the various tests and use proper methods. What you in haste may call a bilious attack, may mean appendicitis; a show of blood with cramps, a false pregnancy; a gastralgia or chronic attack of indigestion may, in careful hands, be diagnosed gall stones; a supposed hysterical contraction of the throat, with rapid pulse, treated continuously with nerve sedative, becomes a thyroid poisoning without, perhaps, marked exopthalmos. Use your test tube, microscope X-Ray, stomach tube, on all occasions, no trouble being too much to ascertain the minutest bit of information about your patient and if you have not time yourself to do it, have some one do it for you. Get in the habit of suspecting; prove the region affected guilty of some disease until you have established its innocence, taking nothing for granted; and do not beguile yourself into the belief that because you have treated the family for years, you know their constitutions; that you can intuitively recognize the onset of serious disease. Make pathology an earnest study, and you will seldom be caught napping. Your knowledge of surgical conditions should be theoretically as good as the surgeon's. He will only exceed you in larger experience and a knowledge of surgical technique, but your powers of observation should be as good, and your deductions from known facts equally sound.

The careful, harmonious relation between clinician and surgeon should accomplish much for the good of the patient and our standing in the public eye. The patient is usually made to understand that after an operation which means detention in a hospital and much expense, as well as some pain and inconvenience, like waving a mystic wand, they are suddenly to be made whole again. Grievous disappointment frequently follows. The physician says, "Well, you have had your operation and should be well;" the surgeon says, "I did my work satisfactorily, and your family physician should now administer tonics and see to your well being." The patient, through some friend, consults an osteopath, and though I do not understand their technique, I imagine the effect is much like massage scientifically administered. Some such aid is what the patient has required; nerves are soothed, the equilibrium of the circulation restored, the patient makes a satisfactory recovery, to the credit of the osteopath and his technique, rather than to the physician and surgeon, by

whose efforts restoration to health was made possible, but who overlooked their entire duty in the practice of a few details in the convalescence.

Educate your patients in your daily contact with them, and lift them from the state that makes them incline to every new wonder-working fad that arises; let them understand your own and the limitations of your science, but show them its possibilities. Be neither narrow nor prejudiced, but receptive of knowledge from whatever quarter it may come; be always a factor, by your attitude towards the public, that represents the dignified nature of your calling and compels respect. Put no man's knowledge or ability beyond your own comprehension or acquisition and you will stand in the public eye like a tower of strength, helpful alike to patient and brother physician.

REPORT

OF THE

BUREAU OF GYNÆCOLOGY.

"Cancer," - - - - - - - - - WILLIAM J. SHREWSBURY.
"Ultimate Results in the Operative Treatment of Carcinoma of the Pelvic Organs," - - - - - DEWITT G. WILCOX.

CANCER.

W. J. SHREWSBURY, M. D.,
BROOKLYN, N. Y.

The whole subject of Cancer, as regards its cause and its cure, is still in the air. It has not yet got down to the earth where it may be reached by mortals. We believe this statement will be accepted as correct by the medical world in general. Notwithstanding the enormous work which has been done the sullen Sphinx refuses to give any sign, and utters no reply. Cancer, to the popular mind—certainly to its victim—is the most hopeless thing named. On account of its dreary history and fateful prospect, it is as dismal a word as ever came creeping out of the womb of Despair.

Among the innumerable forms of life which people the air, the land, and the waters, the Kraken is the most repulsive, and fills the cup of horror to the brim. This unspeakable mollusk begins its

existence and spends its days in the unfathomable caverns of the sea. Mysterious in its origin and habitat, frightful in appearance, terrifying from its strength and all-consuming purposes, and possessing the power to veil itself at pleasure in the obscurity of its inky secretion, it is the King of living Terrors!

Cancer is the very Kraken among diseases. Mysterious, voracious, cruel, hidden in obscurity, invulnerable, malignant.

Whenever we discover a tumor of any kind, the patient or his friends are pretty sure to launch this question at us—"What is the cause of a tumor?" If we are wise and fair, we tell him that the cause of tumors is not yet understood. If we are otherwise we proceed to appear to explain a reason for the growth. We hand him out what may be called scientifically a lemon of language. (Citrus Verbosum.) If our questioner be easily contented, he takes his lemon away and keeps it carefully to show to his friends when occasion demands. If, on the other hand, he masticates it in his mind, he must reflect something like this: "The fruit which the gentleman gave to me is fair to look upon, but the flavor is as the flavor of other lemons."

There are two theories given to us to-day to choose from in considering the cause of cancer. One is the theory of infection, which supposes that a cancerous growth is the result of an external parasite, which enters the body, and by its pernicious action starts and develops the neoplasm. Those who believe this theory, and hope in time to demonstrate its truth, point to tuberculosis as a disorder which has only in our own time been proved beyond doubt to be caused by a bacillus. They forget that ages before Koch, observant men have been found standing here and there along the stream of time, like voices in the wilderness, proclaiming tuberculosis to be infectious, from facts which they had seen. They forget that many days gone by this disease was communicated by experiments of innoculation. Tuberculosis would have been accepted as infectious long before elaborate and overwhelming proof came to hand, the same as smallpox and scarlet fever were, except for the fact that it is a plant of very slow growth. The distance between planting and reaping was so great as not to present the association of cause and effect to an ordinary observer. Smallpox and scarlet fever have all along been known as infectious, though the organisms responsible have yet to be seen.

Not at all so with cancer. In the millions of cases observed and recorded, there has been no foothold for the supposition that at any time the disease was conveyed from a patient to an attendant or relative. The cases in which two people who were dwelling together both became victims, are so extremely few, that considering the frequency of cancer, they may in all fairness be set down to coincidence. There is no time nor necessity to go into the question of innoculating mice and other animals, and producing thereby morbid growths, except to say that none of these experiments have added the slightest support to the microbic theory; and further, that there

can be drawn no analogy of value between the forcing of uncertain tumors in the mouse under abnormal manipulation and the spontaneous appearance of cancer as it occurs in man under the ordinary conditions of life. In dealing with the cause or origin of cancer, we have to do with cells, not with masses, and a group of cells may just as effectually be injured or irritated into an unhealthy state by a hypodermic syringe or a scalpel, as by a bludgeon or an axe. We submit that while research has not been able to prove that malignant disease is caused by organisms, it has gone far enough for us to be reasonably certain that it is not so caused.

The other theory is the well-known one of Cohnheim, which is intended to account for cancer and all other neoplasms. It is so interesting that we quote the following exposition of it from the able work of Dr. Nicholas Senn on the "Pathology of Tumors." Dr. Senn supports this theory after advancing it a step further. He says:

"Cohnheim referred every tumor to its proper embryonic layer, and claimed that a tumor never had its origin from mature tissue, but always developed from a matrix of embryonic tissue. This essential tumor-matrix he traced back to its embryological source. He believed that during the process of cell-differentiation in the embryo groups of cells not utilized in the growth of the embryo, or displaced, were arrested in their development, and remained in a latent condition until their activity was awakened later, when the product of their proliferation resulted in the formation of a tumor. This theory found many supporters, but at the present time only a few authors uphold it in its entirety. It has much to recommend it, but it does not satisfactorily explain the origin of all tumors. In the absence of better proof of the origin of tumors, the author will adhere to "the doctrine advanced by Cohnheim, and in addition to it will claim that *the essential tumor-matrix may be composed of embryonic cells, the offspring of mature cells which for some reason have failed to undergo transformation into tissue of a higher type, and which may remain in a latent immature state for an indefinite period of time, to become, under the influence of either hereditary or acquired exciting causes, the essential starting point of a tumor.*"

It is our opinion that here we are on the road to the truth about the cause of neoplasms, but that the theory is lacking in simplicity and directness. It is too fanciful, and draws too much on the imagination. Moreover, we hold that the idea of groups of embryonic latent cells, scattered at random through the organism, awaiting some imaginary stimulus to start them on their evil way, introduces a complicated and unnecessary element into the study of tumor evolution. We agree with these doctrines so far as to believe that a neoplasm may have its foundation in the embryo, but not necessarily always.

It is the privilege of everyone to gather for himself a scaffolding of facts, and from that height to project his vision into the abyss of the unknown, if haply from thence some conclusion may be drawn

which shall satisfy the reason. In this way, every theory is constituted, and if it harmonizes with all the facts relating to it, and explains what longs for explanation it is entitled to consideration.

Therefore, with diffidence, we offer still another theory. We do not pretend to any new discovery, but have strung together certain axioms and well-known facts in the endeavor to simplify our conception of the cause of morbid growths. We shall try to embody this theory in the following propositions:

Individual life begins with cell evolution and control, which never ceases until the end of life.

There must be, and therefore there is, in each individual, some power or force, which pervades every part of the organism, and not only presides over the budding of new cells, but modifies them and arranges them, and holds them in order, according to strict law. This force performs its allotted work independently of the nervous system, for it operates before the presence of a nervous system, and indeed, the nervous system is one of its products.

This force is probably akin to magnetism, and may be called the X-force. It is easy to conceive that its action may be impaired by causes either within or outside of the organism.

A neoplasm is an independent growth within a living individual caused by the escape of cell elements from the control of the X-force.

In a benign neoplasm control is more or less impaired, and such a growth may be composed of any variety of cell.

In a malignant neoplasm control is completely lost. Only epithelial cells and connective cells are prone to be absolutely lost to the influence of the X-force. In the first case cancer is the result; in the second, sarcoma.

Such a theory, we hope and believe, covers the whole situation. It takes us nearer to the fundamental cause than any other. It does away with the unnecessary machinery of embryonic cell rests. Simple it is, and yet comprehensive enough to account for every true tumor in either the animal or vegetable kingdom.

It would require more time than can now be spared to elaborate this subject and fortify it with argument and analogies. Such a task would be pleasing and not difficult. Occurrence, recurrence, metastasis, heredity—all the facts of cancer—can be embraced in our speculation.

The term "X-force" has not been introduced for the sake of novelty, but merely to fix attention definitely on the subject. X-force is, of course, merely a manifestation or department of life-force, which shows its presence in few or many ways, according to the complexity of the individual in the scale of creation. But in every living thing the X-force is operative, even in the humblest forms, where it is the only sign of the life-force manifest.

So far as our knowledge extends, such a hypothesis has not been presented before. Whether it be new or not new, we care little, being more concerned that it should accord with reason and truth—that it should be a though worth thinking.

Cancer in man is what we are most interested in, but a consid-

eration of the cause has necessarily led us to the genesis of all neoplasms. We will give a brief glance at human cancer, and see the bearing of our theory. We must take the light of embryology and go to the beginning. Down in the warm embrace of the Graafian follicle the passive ovum lies. Let us earnestly consider this thing, for it means much, and is perhaps the strangest object in the whole realm of nature. This ovum is a finished product of another life. It is not dead. It is not living. Nor is it sleeping, for sleep implies life. It is neutral, and for a little while remains balanced upon the linear borderland betwixt life and death, awaiting destiny. So to speak,

"Standing with reluctant feet"
Where everything and nothing meet.

To-morrow it may die and be a castaway. Again, it may be impressed by that kindred mystery, the sperm cell, and then and there a new life has begun. The central spot of the ovum which we call the primitive cell, begins to bud. Here and now comes brooding the X-force which is to remain, and control all cell production, and repair, and modification, and harmony, even until the instant of death. Neither the maternal cell nor the sperm cell can contain cancer as an entity. But if the sperm cell brings into the chamber of the ovum nothing else, it certainly does bring the X-force, or at least in uniting with the primitive cell it evokes the same. We see no possibility of denying this much. Our theory then simply requires us to suppose that one of these primal cells, which are the starting point of the new individual, shall have been impressed from its ancestral line with an inherent weakness or aberration, or shall have suffered some accidental personal defect in its evolution, with which heredity, properly speaking, may have nothing to do and which prevents a perfect action of the X-force.

This shows the part heredity sometimes plays in the production of cancer and also incidentally may explain the susceptibility to other diseases, which is inherited, though the diseases are not. The individual goes on living his life with this defect, until the further loss of power which comes with time to every living thing, some accident, some irritation, some injury, some interfering disease, or malnutrition, excites a group of epithelial cells, already loosely governed, and the man gets his cancer, which is literally an anarchy of cells. The microscope shows it to be only this, and nothing more. The flame of lightning zigzags in its path from the cloud to the earth, darting hither and thither without apparent reason; and the erratic spark of heredity, coming indefinably through the generations, strikes its appointed spot, in obedience to a law too complicated for our ken; so that the cancer patient you shall see to-morrow is the daughter of that other sad patient who withered of her cancer in the days of William the Conqueror, and of that other woman, more remote, who perished before the flood. However, while it is probable that in most instances the cause of a neoplasm may lie in

a congenital defect, we see no reason for believing that it does in every case. If the cell-controlling force operates every moment of existence, an individual may be born with it in perfect order, and it may become deranged at any period of life.

It is time to leave this matter for the present, and we will do so with just this parting word. There may be those who would condemn our theory on the ground that it savors of the transcendental. We hardly think it does, but if so, we shall plead guilty to the soft impeachment. No man ever yet escaped the transcendental. The man who studies physiology and biology, whether he knows it or not, has gone above the material, and is soaring in the clouds of the transcendental. The mere materialist, if such a being could exist, would be a good brother to the cobblestone. The doctor of medicine can least of all afford to turn up his nose at the transcendental. His business is right in it and mingles with it. You and I and our patient, and our dog, and the plant which decorates our home are each a cunning and inseparable mixture of the transcendental and the material.

Of the treatment for cancer we shall say little. The only prospect of cure at present appears to lie in the direction of surgical operation for removal, in the effect of light influence, or possibly in some serum. These things do not come within the scope of this paper, and for the hope to be built on any of them every man must consult his own experience, for the claims of others vary exceedingly.

Medical treatment, that is, the administration of drugs for the cure of cancer, is of absolutely no value. The history of the disease has brought to notice many remedies which have been used with hope, and being found wanting have been discarded. Probably no educated physician to-day believes that the remedies we have will cure cancer, or even retard it for any length of time. Arsenic, perhaps more than any other drug, has been supposed capable of influencing it. If any man knows of a case which he is sure was healed, or positively benefited by arsenic or any other drug, let him tell about it. We do not. Therefore, if we are to build on our personal experience we must say that the medical treatment of cancer is purely palliative. We have never seen a single case in which the growth responded to internal medication. Palliative treatment merely consists in relieving the symptoms of distress, and building up the strength. Of course, when a patient has his body racked with suffering, and his spirit broken with apprehension, he will have many disorders of a reflex nature, and these will be often reached and relieved by homeopathic remedies in a manner sometimes surprising. This much we are glad to testify to, for we have seen it repeatedly. Suggestions for palliation are scattered through the text-books, and the remedy to suit each patient, so far as it can do so, is to be found at somewhat inordinate length in the Materia Medica. It would seem a waste of time to mention these matters in detail, and we do not wish to make ourselves obnoxious to the Society for the Prevention of Cruelty to Doctors.

DISCUSSION.

STUART CLOSE: The line of thought presented in the body of this paper by Dr. Shrewsbury compels attention, and will probably receive the assent of every physician who has reflected upon the great subject of cancer. It penetrates directly to the heart of the problem, and brings to bear upon it the principles of natural law. It makes for simplicity, and simplicity is characteristic of truth. There was no need to anticipate or depreciate the charge of transcendentalism, because, as Dr. Shrewsbury has pointed out, studies in biology, physiology or pathology are inherently and necessarily transcendental. All studies of matter are valuable only as they serve to reveal to us the action of those forces which lie behind matter.

The broadest, the profoundest, and at the same time the most practical conclusion of science is that *every process and every function in every realm of nature is governed by law.* This is so well known, and has become so familiar by constant repetition that we sometimes lose the sense of its force, or see the operation of law in one sphere, perhaps, while we fail to recognize it in another. This is the basis of my one criticism of a part of the otherwise most admirable paper of Dr. Shrewsbury's.

Beautifully has he portrayed for us the genesis and evolution of individual life in organism. He focuses our attention upon that breathless moment, fraught with such tremendous possibilities, when the mysterious cell-union of male and female principles brings into existence a new being, which not only partakes of the characteristics of both its progenitors, but is an epitome of all its ancestors, under the law of heredity. Here, at this moment, it receives the impress of those mighty forces which are to work out good and evil, subject always, however, to the higher law of individual development.

There is no escape from law. It meets us at every turn. It reigns in biology. It reigns in pathology. *It reigns also in therapeutics.* Having recognized and portrayed the operation of law in its origin and pathology, and having defined its essential nature in terms almost identical with terms used by the immortal Hahnemann, how can he fail to see that its means of cure, if cure there be, must also come under the operations of law upon the same dynamic plane of existence? Shall not He who has revealed, through science, the law of pathology, also reveal the law of cure? We believe that the law of cure has been revealed, and that cancer forms no exception to the law. Failure to cure results *not from absence of law, but from ignorance of law.* Failure to cure, in any curable case, results from failure to recognize all the elements of the case, and from failure to fully approximate the remedy to the case under the law of similia.

The cells which escape from the control of what Dr. Shrewsbury calls the X-force, come at once under the operation and control of another force favorable to the upbuilding of a tumor, but inimical to the life and integrity of the organism, as a whole, from which it draws its sustenance. It will not do, therefore, to call cancer "an

anarchy of cells," because even anarchy has its laws of origin, development and existence. The cancer obeys a law of its own, but it is a law which conflicts with the higher law of the organism. The autocracy of the life force may have been assailed and weakened, perhaps crippled, but there is a stage at which cancer is curable. Under the wise and timely application of the higher law of healing, the king may be reseated on his throne and the usurper expelled. We must always distinguish between curable and incurable stages of disease. There is no such thing as an "incurable disease," but only an *incurable stage* which may be reached in any disease, and any period.

To me, it is unthinkable that cancer is not, and cannot be brought under control of the law of cure, although to be more accurate, I should say the *individual victim of cancer*, for the law of cure does not apply practically *to the disease*, in the generic sense, but only to the *sick individual*. Neither does the law of cure relate only to the administration of medicines, but to every means by which the perversions and discords of the vital force represented by disease are to be remedied. Cancer, in any individual case, will never be cured until every principal cause, be it mental, moral or physical, or all these combined, shall have been sought, recognized, in their true relations, estimated at their true value, and brought under the control of the higher law of healing and regeneration. This I believe possible of accomplishment in a certain proportion of cases, and my belief is based upon personal demonstration and experience in a number of cured cases.

Very subtle and complex, indeed, are some of the causes of cancer, far beyond and below any superficial or material irritation of tissue. They are sometimes found deep in the mental or psychic life of the individual. Frequently have I traced mammary and uterine cancer to long continued, repressed, silent, secret grief, mingled with that gnawing sense of injured self-love and humiliation arising from unhappy, uncongenial or unfortunate relations in the sexual life. Dr. Shrewsbury has directed our attention to the psychological moment of conception as the place and time when the cell receives the "hall mark" of its production. I am convinced that it is in the psychic sphere in after life that we must seek for the causes and most significant symptoms of the greatest and most mysterious of all the scourges of the human race; and having found them in any individual case, we must bring to bear upon it all the resources of enlightened education, philosophy and religion, as well as medicine, until we change the mental and spiritual point of view, the trend of thought, and the physical functioning, and bring them under the dominion of the higher laws of existence.

Depend upon it, "*the plane of the remedy must approximate the plane of the disease.*" The patient must be "transformed by the renewing of his mind" as well as by the similar medicine.

Depend upon it also, that the search for cure of cancer through surgery alone, or by any drug or serum chosen upon empirical

grounds, will prove as elusive and as fruitless in the future as it has in the past. "That way madness lies." Not until we follow out the line of thought so ably suggested in the body of Dr. Shrewsbury's paper, and *approach the problem of cure also* on what he happily calls the "transcendental" side, shall we be able to claim the divine promise, "Knock, and it shall be opened unto you."

W. H. FREEMAN: Dr. Shrewsbury's paper is interesting, and contains much food for thought. I must, however, take exception to his opening statement that the cause and cure of cancer is still in the air, and not within reach of mortals. Every truly scientific and up-to-date Homeopath knows that this is not so. We who have studied the matter carefully, and thoroughly investigated the individual and family histories of our cases understand the etiology, as well as the curative homeopathic treatment of this disease. The etiology is always complex, and the treatment by homeopathic remedies exceedingly complicated and difficult.

By curative treatment, I mean the accurately scientific mode of administering individualistic, specific medicines which bring about positive curative reaction and result in the cure of an admittedly small percentage of cases; the indefinite prolonging of life with comfortable existence and comparatively good health in a large percentage of cases, and the palliation and relief from suffering in those advanced cases which are practically moribund before beginning treatment. As has just been said, the method of treatment for this class of diseases is extremely difficult, and requires the highest degree of homeopathic skill. It will never be successful in the hands of that class of cheerful idiots who would prescribe hepar for the next case of fibroids, because someone else had cured a case with this particular remedy previously.

The homeopathic treatment of cancer is the same as the homeopathic treatment of measles and chicken pox. That is, through the administration of remedies exactly similar to the group of symptoms most recent and most prominent at time of making each new prescription. The only difference is the difference between the two classes of diseases and their etiology—the one extremely simple, the other extremely difficult and complex. Arsenic is only one of 150 remedies that may be needed.

I know many of these statements will be questioned, and considered as driveling rot by many of the profession, but I also know positively, as the result of careful and painstaking study and clinical experience and investigation, that they are true, and many of my friends engaged in the same line of work are able to verify these statements.

The etiology of cancer can be summed up by the phrase "suppressed diseases" and *the inheritances of same.* The etiology is almost invariably complex, and includes the so-called psora of Hahnemann, meaning thereby the after effect of pseudo cures, such as skin diseases by local applications, malaria and grippe by quinine and other palliatives, and imperfect recoveries from typhoid and

the zyrotic diseases, the removal of enlarged glands, enlarged turbinateds, tonsils and adenoids by local treatment, without removing the constitutional defects causing same, which will often remove the growths at the same time, the suppression of leucorrhœa and catarrhal discharges by palliative, non-curative methods, etc., etc., as well as the suppression of syphilis with large doses of mercury and the iodides; the suppression of gonorrhœa and vaccination, including especially the inherited morbiditis resulting from same in our ancestors.

The etiology of cancer, tuberculosis and many forms of insanity are practically identical, the difference being chiefly in the environment and the degree of resisting power on the part of the individual; tuberculosis usually appearing in youth, cancer and insanity usually later in life.

This is the day for specialization. Ninety-eight per cent. of all cases are medical, while ninety-eight per cent. of all doctors are more inclined surgically than otherwise; and but very few have more than the faintest inkling of the vast possibilities of drug science. There are not enough surgical cases to keep the surgeons busy, and not a fraction of the necessary number of competent homeopathic specialists for the vast multitude of cases requiring their services. The time is ripe, and the field and its possibilities inexhaustible for all who will become competent to practice this greatest of all specialties.

M. R. LEVERSON: I was very pleased to hear Dr. Freeman refer to one cause of cancer, of which I have a specimen here. I call attention to the fact, which I think no physician will question, that one of the concomitants—I do not say cause, but one of the concomitants—of cancer, without which cancer cannot exist, is excessive proliferation of cells. Now, we know cancer may occur from a blow on the breast, the beginning of which is the constitutional taint, no doubt, connected with it; that a rapid proliferation of cells is set up by the blow. The human race matures in from twenty to twenty-five years. The bovine race matures in from four to six years. When we sow the seed of the cow into the tissues of the man, we are sowing a cell which proliferates much more rapidly than the normal cell of the human being. I never refer to statistics in proof, but in confirmation, of arguments. Now, it is since the almost universal introduction of bovine inoculation that cancer has taken its most rapid growth; and, in further illustration of that fact, cancer, from being a disease of old age, has now become a disease from youth to middle age. Statistics establish those facts unquestionably, and confirm the fact that the result of implanting the cell of the cow into the human body is to set up a more rapid proliferation of cells, which results, in some cases, in cancer.

JOHN L. MOFFAT: Dr. Shrewsbury is simply giving another name to something that has had many a name before now. I believe most of the authorities, if not everybody who has studied cancer,

virtually agrees that it is, in the same or different words, a perversion of the forces of growth; this is coming right back to the transcendentalism and the force. It occurs to me that that should help people to believe in the possibilities of medicinal action. I am not talking of the question of dose at all. The homeopathic school stands for a belief in medicine. I am sorry to say that I see a great deal of Oslerism in our ranks. I am coming in contact with more and more members of our school who are having less and less faith in medicine. We must have real homeopathic papers and our really homeopathic meetings, in order to nurture faith and confidence in our remedies, but it is essential that these be scientific, and not on the plane of the experience meetings of the Christian Scientists, etc. You know that is what I am standing for, and have been advocating in all our societies for years. *Clinical reports must be demonstrations, not mere assertions!*

I was recently told by a surgeon that within a few weeks of the report of the care of a case of cancer of the uterus by medicine, he was called for metrorrhœa, and found the "cured" patient in an awful state. I forget now whether he felt that he would succeed in operating or whether it was inoperable. I think he said it was inoperable. But it had been reported as cured within a few months of the time when he saw it.

DR. SHREWSBURY: I would like to say here that the possibility of cure, to which Dr. Close referred, I believe in. I merely do not see that we have got to that possibility at the present time. I will not say anything more about that. That is my stand on that question.

I still believe that cancer is an "anarchy of cells." The common tumor, the innocent tumor, is a "rebellion of cells." Cancer is an "anarchy of cells," and its cure is an "insanity of cells." I do not know anything to-day about the cure of cancer by serum. We have heard a great deal about it, and we have heard a great deal of contradiction of it. There are a great many claims made about the absolute and positive cure of cancer by surgical operation. I have practiced medicine twenty-six years, and have seen my share of cancer. Every patient has died except one, and she is going to. I am sorry to say that, Doctor, but every case of cancer I have seen has died. Some of them have been operated upon in the very beginning, and the disease has come back. The cancer was removed, and the X-force was wrong yet. The same thing happened over again to the patient. It was not a recurrence, it was a continuation of the same defect operating upon that individual all the time.

With regard to the name "X-force," I care not what name you give it. In order to discuss the thing, you have to have a name for it. You can call it X-force, cell force, John Thomas force, or whatever force you like, but it is there just as surely as we are here, and if you do not recognize it, there is no use in talking about cancer.

ULTIMATE RESULTS IN THE OPERATIVE TREATMENT OF CARCINOMA OF THE PELVIC ORGANS.

DEWITT G. WILCOX, M. D.,
BUFFALO, N. Y.

As cancer attacks the uterus far more frequently than it attacks all other organs of the pelvis, I shall confine my remarks to that organ exclusively, notwithstanding the subject assigned me designated the entire pelvic viscera.

By ultimate results, I take it, is meant the percentage of complete recoveries, without recurrence, following operation or in case of recurrence, the time at which such appears. As the question of recurrence depends almost entirely upon the stage of progression which the cancer has reached, I must, of necessity, consider first the question, when should cancer of the uterus be operated upon?

When Oliver Wendell Holmes was asked at what age should a child begin its education, he replied, "About two thousand years before it is born." If we were able to remove a uterus about six months before the cancer appeared, the probabilities are we should cure our patient and there would be no recurrence; but as we are not able to do that, the next best thing to accomplish is to remove it just as near that stage as possible.

Much as the physician has learned about cancer of the uterus, and much as the public has been educated upon the subject, there is still a deal of hammering to be done ere we shall impress upon both parties the tremendous importance of early recognition.

The easy indifference with which the average woman and certain physicians regard symptoms which fairly indicate cancer of the uterus, is enough to induce the entire profession to enter upon a crusade of education. Two years ago a commission was appointed by the American Medical Association for the purpose of investigating cancer of the uterus, with reference to increasing the percentage of cures by operation. This commission consisted of well-known surgeons and investigators, which made a detailed report before the Section on Obstetrics and Gynæcology, at the 1907 meeting of the American Medical Association. The following is a summary of their report:

A. CANCER IN GENERAL.

1. Cancer is primarily a local disease.

2. In its primary stage it is so localized that every particle can be removed; it is therefore capable of complete eradication with a resulting permanent cure.

3. While still local, it causes, as a rule, little or no discomfort, and no loss of weight. The deviations from normal seem slight, indeed, and yet they are very definite, easily recognizable, and demand immediate investigation. Upon its first recognition, immediate removal by a competent operator is the requisite for a cure.

4. The disease, if not at once eradicated, progresses with great rapidity to other parts of the body by continuous growth and by metastasis.

5. When it has passed beyond the bounds of the original organ, however slight the involvement may be, the prospects for relief grow rapidly less with the days and with the extent of the involvement.

6. Serious symptoms of cancer rarely appear until an inoperable stage of the disease has been reached.

7. The classical description that has so long stood as a picture of cancer (pain, hemorrhage, offensive discharge, emaciation, profound anæmia and an ashen hue) is really a picture of impending death, due to advanced cancer, and irrevocably indicates the impossibility of a cure at this stage.

8. The time of operation (measured by the progress of the disease) is much more important than the type of operation, for a simple operation, if performed very early, may effect a cure, while the most radical at a later stage is of no avail.

B. CANCER OF THE UTERUS.

1. Cancer of the uterus is the most frequent form of primary cancer.

2. Cancer of the uterine cervix is much more frequent than cancer of the body of the uterus, and is much more malignant because it spreads beyond the limits of the uterus much more quickly.

CANCER OF THE CERVIX.

A critical study of the subject leaves little doubt that removal by operation, while the disease is still very limited in extent, offers the best and practically the only chance of cure. The main hope, therefore, lies in operating before the disease has passed beyond the limits of the uterus (either by metastasis or by direct extension), because it has been demonstrated over and over again that even microscopic particles of cancer, which are not removed, continue to grow.

An early diagnosis is possible in a large percentage of cases. Probably over fifty per cent. of the operable cases, and a much higher percentage of the inoperable ones, have been bleeding for six months before any treatment is considered. As the course of the disease is usually rapid, six months, or even less, of neglected uterine bleeding permits the disease to extend so far that only a small percentage of the cases can be cured. Even in the face of this statement, it must still be remembered that many apparently

advanced cases have been cured permanently by the more recent radical operations.

SYMPTOMATOLOGY OF CANCER OF THE UTERINE CERVIX.

(c). While there is no characteristic early sign of cancer, bleeding or a blood-stained discharge is usually, but not always present. It may be:

1. Slight, "only a show," appearing at irregular intervals, as. on exertion, after sexual intercourse, using a douche, or straining at stool; or it may be slight, but constant, the patient noticing that her clothes are slightly stained on taking them off at night.

2. In other cases the bleeding may be more profuse, simulating a prolonged or irregular menstruation, or a return of the menses after the menopause.

3. In still other cases, severe hemorrhage may occur, appearing either as the result of some unusual exertion or during menstruation, or the cause may not be apparent.

(d). In a small percentage of the cases bleeding may be absent, but usually some other sign, such as an unusual leucorrhœal discharge, calls attention to the growth. In a small percentage of cases all symptoms referable to the growth may be absent for a long time.

(e). Pain, caused by the growth, usually occurs later in the course of the disease, and must be differentiated sharply from pain arising from pelvic trouble independent of the cancer, such as inflammatory conditions of the tubes, ovaries, etc.

3. It is evident that all women suffering from uterine bleeding or other symptoms referable to the uterus, should be examined as soon as possible, and if the diagnosis is not clear, the uterus should be curetted or a small piece of the cervix excised and not thrown away, but preserved in ten per cent. formalin or ordinary alcohol and sent to a competent pathologist.

4. All symptomatic aberrations referable to the generative organs of women about the menopause should be looked upon as the possible beginning of malignant disease, and an immediate examination should be urged. If a suspicious area is found, prompt measures for its certain diagnosis by the microscope should be instituted.

(a). COURSE.—Its course is rapid. It passes beyond the limits of the uterus proper (and hence becomes practically incapable of complete eradication) in a period which usually varies between thirty days and six months from the outset of the earliest symptom. When it runs its course undisturbed, patients rarely live more than three years. About three-fourths of them die within two years; about one-third within one year after the first manifestation of the disease.

That report is so filled with food for thought that it should be

committed to memory by every physician and every woman past thirty-five years of age.

The responsibility for so low a percentage of cures in cancer of the uterus is not upon the surgeon, but primarily upon the family physician, who fails to recognize the early symptoms of the disease, and secondarily, upon the women themselves, who fail to seek aid promptly.

As above stated, a woman who has passed the climacteric should regard with serious suspicion any unusual vaginal discharge, whether it be blood, serum or mucous; nor should she be less alarmed because the discharge of blood was slight, for in the early stages of cervical cancer the ulceration is so extremely slight, that the discharge of blood may not be enough to stain the clothing; yet upon examination, a cervical ulcer will be discovered.

The physician who to-day waits for the confirmative evidence of uterine cancer, such as foul discharge, cachexia and profuse flow, before making his diagnosis, is simply waiting to sign the death certificate of the victim of his procrastination and ignorance. Those symptoms never appear until the case is absolutely inoperable, and should, under no circumstances be looked for as diagnostic. They present the complete picture of the disease, but in no sense the foreshowing of it.

The province of the physician to-day is to discover the foreshowing of all disease. His responsibility in this line becomes greater every year, as he knows more of preventive medicine. "He does well who, in the forest wild, slays the monster and saves the child; but he does better and merits more, who drives the wolf from the poor man's door." So he does well, who in the struggle against death, throttles the monster—disease—and saves the victim; but he does better and merits more, who recognizes the shadow of the approaching monster and thus saves not life alone, but pain and disability consequent upon disease.

The technique is now so perfected that in nearly all cases conservatively considered operable, the diseased tissue can be completely removed; that leaves the one remaining obstacle—opportunity for early operation. So late even as the past year, Dudley, of New York, estimates that only in about six per cent. of cases of uterine cancer is the operation performed sufficiently early to circumvent the disease. Who is responsible for the ninety-four per cent. which passed on to the inoperable stage and consequent untimely death. The responsibility must be divided between the ignorance or indifference of, first, the patient; second, the attending physician.

The following graphic rules, which Dudley has formulated, are worthy of the most minute following:

1. Any deviation of the menstrual period in the way of an excess or an intermenstrual discharge, especially in women beyond thirty years of age. The most suspicious of these are (a) a mere show

after slight exertion, defacation or coitus; (b) increasing length of the period, even if only one day more than has been her established habit. Every woman is a law to herself in this respect.

2. An exacerbation in amount or change in character of the discharge in a woman who may have had a simple leucorrhœa for months or years. Of these changes a free, aqueous, acrid, or blood-tinged discharge is especially portentous.

3. A leucorrhœal discharge in a patient who has never had it before.

4. Every atypical discharge in a woman after the menopause. These cases are especially liable to cancer, and should, if possible, be even more exhaustively examined.

5. Pelvic pain of more than a few days' duration should always be an urgent reason for examination although it is very seldom an early symptom of cancer. It is very evident that the chief stress in symptomatology points not to diagnosis, but to the urgent necessity for an examination, for on this almost exclusively the diagnosis must rest.

Now, as to the ultimate results: Given the premises that uterine cancer is a local disease in its early stage, and we cannot deny the truth of this premise, and given the opportunity to remove that disease when still local, there should be no defensible argument why all uterine cancers should not be eradicated permanently at the time of the primary operation.

This position has been undisputed in theory for many years, and is truer to-day than ever. The only difficulty has been, first the opportunity to see the case early; and second, the technique whereby all of the diseased tissue could be removed. Those two obstacles once removed, we shall have as good statistics in operations for cancer of the uterus and its ultimate cure, as we have for fibroids, ovarian tumors and gall stones.

Brunt, of Germany, estimates that in Mackenraldt Clinics 45 per cent. of the women operated upon for uterine cancer in 1902, are now well and show no evidence of recurrence, after a period of five years.

In Chrobak Clinic 25 per cent. of the cervical cancers and 76 per cent. of the uterine cancer (body) cases have remained well after ten years' observation.

Werthheim gives his report as having 22.5 per cent. recoveries without recurrence. At the close of the first fifteen years' work at the Johns Hopkins Hospital, 24 per cent. of the women heard from were living and well, after not less than five years, and in many cases ten years following hysterectomy for cancer.

When it is remembered that the clinical course of uterine cancer is very rapid (when unoperated), patients rarely living over three years, and 75 per cent. dying within two years, it is no small victory to enable even 25 per cent. of cancer victims to remain well after a lapse of five and ten years.

Just a few words about the ultimate results to be hoped for in inoperable cases. The physician and patient need not give up all hope simply because the case is inoperable. A thorough curettement of the cancer, followed by a deep cauterizing, will many times do much toward checking the progress of the disease. The treatment certainly lessens pain, and overcomes greatly the foul discharge. This cauterizing can be repeated at intervals sufficiently frequent to check the spread of ulceration. I have had a number of such cases under observation where the patient has been kept comfortable for three or four years. The treatment of inoperable cancer by the use of acetone is highly recommended by many recent writers. I have had no experience with it.

In closing, I cannot do more than re-echo the statement of all writers upon the treatment of uterine cancer; *i. e.*, until the cause of cancer is discovered, we know of no better treatment than the knife, and that used without stint. We know the disease in its early stages is local. We know it begins so insidiously that the victim is rarely aware of its presence. We know that but a small per cent. of cases is discovered sufficiently early to promise a cure by operation, and lastly, we know that the responsibility for this failure to make early discovery lies in the lack of knowledge possessed by the women regarding the onset of cancer, together with the ignorance or indifference of the physician who first sees the case.

Appendicitis is no longer a neglected disease, and the reform has been brought about through a campaign of education. The patient now demands prompt treatment, even if the physician fails to furnish it. So may it be hoped that uterine cancer will soon cease to be a neglected disease.

DR. WILCOX (commenting in the course of his paper): Let me say, with regard to the statement made this morning that cancer is not curable by operation or any other means, that Dudley is right in that; that only six per cent. of the cases have not passed the operative stage, and in view of that fact, certainly, the opportunity for the surgeon is very limited.

WALTER G. CRUMP: I can most heartily endorse the precepts of this paper. My operative experience with cancer is that the high percentage of recurrences is due to delay. If you get a cancer early there is no question but that its radical removal will prevent its recurrence. One feature that has been impressed upon me by my experience in this line is that frequently these inoperable cancers which so frequently come to the surgeon, are not discovered by the general practitioner until they have become inoperable; and often the cause of that delay in discovery is not because the practitioner has not had symptoms brought to his attention, but because very often his relations with the patient are so intimate socially that when he gets some symptoms of uterine bleeding, some bleeding after effort, after coitus, or something like that, he does not interrogate as to those symptoms, doesn't search to find out the cause

of them. He feels that because he knows the patient so well he would rather not do that, so he postpones it until the symptoms which Dr. Wilcox so graphically described have established themselves before he proceeds with an examination which would lead to a diagnosis.

As one of the younger surgeons, and from my own bitter experience, I want to drop just one word of warning in regard to the operations for these cancers, and that is to proceed to a radical removal of the growth and the avoidance of this inoculation metastasis. It was my experience in early operative procedure to go at things so gingerly and to be so poorly equipped in surgical technique, that I would distribute through the wound islands of these cells, which would take on riotous living, become anarchistic and develop themselves through the wound and start up islands of recurrence of cancer. I think anybody who attempts to do these operations should early school himself in the up-to-date technique of handling these cases so as to avoid as much as possible the distribution through the wound these pathological particles of the growth.

We all meet cancer cases which are inoperable, and there are just one or two points that I have discovered by experience in that line that I would like to speak about. We have these cases with pain, hemorrhage, putrid discharge, which are the main symptoms that we have to contend with, and, in these inoperable cases especially, of cancer of the pelvic organs, where the uterus has been slightly eaten away and eroded down into the larger blood vessels, we frequently are called on to meet the emergency of a severe hemorrhage. In my experience, one of the best means of meeting that (after, of course, you have curetted the uterus and cauterized it, and then have the recurrent hemorrhage), is to tampon the uterus; or, if it is a cervical cancer, tampon the upper segment of the vagina, with gelatinized gauze. Get a box of Cox's gelatine at the grocery store, make up this solution of gelatine, add a little adrenalin to it, and run your gauze through that. This adrenalin will not only stop the hemorrhage almost invariably, but it will also shrink down the blood supply; and there is no doubt but that it delays the rapidity of this anarchy of cells.

Another good method is to take little pledgets of cotton, dip them in equal parts of formaldehyde and adrenalin, wring them out so that they will not drip, and run down into the vaginal portion of the canal where cancer does not exist, and pack a good many of those little pledgets into the diseased area. It will cause a necrosis, which will come away in ten days or possibly two weeks. You need not bother about taking out those little pledgets; they will come away with the bleeding, or the douches that will follow, and that often will stop hemorrhage.

I have just had some experience with the use of radium in these cases, and I want to tell you of one or two little things which may be of interest. I had one case of cancer of the cervix, where it had

spread on to the vaginal vault in a woman about thirty-eight years of age. I snipped out several little fragments of the growth and sent them to one of the most eminent pathologists in New York. The diagnosis was returned as cancer. I sent the case to Dr. Dieffenbach, and he continued to treat that case with the insertion of the radium-coated celluloid pencils. That case has now been under observation for about six years. The woman now has a little hard nodular mass up back of the cervix. She had even gone so far as to have quite a cachexia. She is still alive. The cancer, I think, is still there, hardened down into a little nodule; once in a while lifts up, and she has to have a radium pencil inserted. There is no doubt in my mind but that that has delayed the termination of that cancer.

Another case I have had under treatment this past winter and summer, where the cancer had spread and all the symptoms of impending death were present. I saw the case after it was given up and had gone to bed. In that case the introduction of these radium-coated celluloid pencils has kept the woman alive until just about six weeks or two months ago; and she had no hemorrhages after the introduction of these pencils. I want in closing, to just add my experience that the recurrence of cancer is the recurrence of delay.

CLINICS

AT THE

CUMBERLAND STREET HOSPITAL.

ORANDO S. RITCH: It was the intention on the part of this Committee to carry on a minor surgical clinic in preference to a major, with the view that the cases presented would be far more interesting to the general practitioner than would major cases, in which he never intends to perform such operations; but to facilitate matters, it was deemed wise to divide the clinic into three parts. First, a major operation performed by Dr. W. H. Pierson; second, a minor surgical clinic, exhibiting such cases as are of interest to the general practitioner; and, third, the exhibition of cases in X-ray electricity and allied branches.

MAJOR SURGICAL CLINIC—REMOVAL OF CYSTIC TUMOR.

W. H. PIERSON, M. D.

W. H. PIERSON: This is an exploratory incision for some tumor, or mass, whose nature is unknown.

The following is the history of the case: The patient, age 29, was admitted to the ward September 7th. Her family history is negative. The patient has always been troubled with headaches at her menstrual period, and occasionally the menses are accompanied by chills and fever. After each of her childbirths she had chills and fever. The patient has had three children besides two miscarriages, the last miscarriage being two years ago.

After her last confinement, which was in December, 1906, the patient noticed a pain in the right iliac region and at the same time had a slight whitish discharge from the uterus. This condition continued for four months. (April.) One morning in April the patient felt something give away, and a large quantity of thick whitish substance gushed out from the uterus, followed by a thin greenish discharge. The physician in charge at the time diagnosed the case as an abscess on the ovary. After the rupture of the abscess the patient noticed an enlargement in the right side of the abdomen,

which gradually increased in size to the present time. The patient is still having a whitish discharge from the uterus, and pain in the right iliac region. By vaginal examination and palpation over abdomen can detect tumor, which is fairly solid and bound down by adhesions. The urinalysis proved negative.

I find, on entry, that the growth extends back to the lumbar region. (Tumor lifted out and excised.) I ligate the stump with Kangaroo tendon ligature. This evidently was attached to a broad ligament. There are a good many bleeding surfaces, on account of the adherent condition. The peritoneum is very, very greatly thickened.

I have the appendix now under my finger, and it is involved in a mass of adhesions.

I am holding on either side of the peritoneum. You see the thick condition on the right side. The other side is very much thickened, but not nearly so much as the right. We are using a saline irrigation at a temperature of 110.

Every step has been digging through adhesions, which has made it very tedious. The growth proves to be simply a cyst filled with pus.

MINOR SURGICAL CLINIC.

R. F. WALMSLEY, M. D.

CASE 1. *Caries.*—The family history of this case is that the father had rheumatism; the mother, nephritis. Otherwise the history is negative. She had chorea twelve years. Since December has had cough with expectoration. Has had night sweats. In December had abscess in dorsal region and back of the left side. She has had no menses. Patient has a hard swelling in the phalanx of the third finger of the right hand, very tender to touch, and still has abscess on the back.

There was a great deal of discharge after opening the swelling, the bones roughened and found to be necrotic. To save the hand as much as possible we left in all the bone that we could. She then was put on calcarea phos. The caries on the bone seems to be lessened. The metacarpal bone was infected. That is where it was cut off. The dressing applied afterward has been the use of bromin solution for an hour, in 2,000 and gradually decreasing from that to 5,000. The wound now is pretty well closed up, and there is no necrotic condition in the bone at the present time. The patient gives a tubercular history, and certainly shows all the symptoms of tuberculosis.

CASE 2. *Catarrhal Appendicitis.*—There have been several of these cases of catarrhal appendicitis and supposed inflammatory con-

ditions that have been brought into the hospital, and by the use of the remedy as indicated we have frequently saved the patient the trouble of a laparotomy, and the patient has gone out well. This patient is shown to show the effects.

CASE 3. *Suppurating Cellulitis.*—This patient was working with a horse-clipping machine when his right wrist was caught in a cog-wheel which was covered with grease and hair. The wrist was badly lacerated and contused, and some of the grease and hair was found in the wound. This former history we take from the patient, because he was not at our hospital in the first place.

The wrist was stitched and dressed at the previous institution. Five days later, before he came to this hospital he complained of pain in the wrist. The stitches were removed, also a great deal of tissue removed. The tendons were not injured. At the time he was admitted to the hospital the wrist was twice the size it is now, and sloughing, and the cellulitis was deep and very penetrating. The wound was thoroughly opened, the stitches removed, and he has also been put under bromin saturation, allowing the arm to soak from one to two hours in a bromin solution, starting at 1,000 to 2,000 and gradually decreasing the strength by the addition of hot water. He soaks it himself. He has gotten now so that he is able to do most of the treatment himself except the dressing of it afterward. The remedy he has been having is hepar sulph. since he has been here. He has run no temperature since his arrival here. On his admission his temperature was 102½. It dropped immediately. I say no temperature—he runs a temperature now between 98 and 99—practically no temperature. We have found that in these nasty suppurating, deep cellulitis cases, by soaking with bromin in that way we get great results, far preferable to those obtained from bichloride or any of the others. Bichloride seems to produce a coagulation of the pus, does not seem to get into the deep tissue; but bromin seems to act not only as a peroxide in removing tissue, but also seems to stimulate adhesions, to go deeper even than arzymol and we have been very fortunate with arzymol in our cases here and these deep-seated cellulitises or inflammations.

CASE 4. *Maxillary Necrosis.*—Previous to this fall all cases of fracture of the jaw, or caries of the jaw, or anything pertaining to the mouth, or that canal, were attended to by Dr. Van Wort, so that I am not quite as familiar with this case as I ought to be. This man has had an abscess on the lower jaw previous to the present time, has had two of them, and the whole right side of the face swollen, the result of a sting by some insect. The patient also said his teeth seemed to be the cause of a great deal of trouble. That is the history as given. He has been operated on twice, operated on by Dr. Van Wort for necrosis of the jaw, and at first we thought it successful; but finally that opened up again. Made a very small opening, and still had quite a bit of pus in this opening here (indicating). They think there is still some necrosis, so whether the history is

correct or not, is uncertain at the present time. It seems there must be some other history back of it that we have not been able to get at.

CASE 5. *Septic Abscess.*—Four days previous to the entry into the hospital of this patient, he chafed his back with a metal suspender clamp. Inflammation set in between the shoulders, which was incised by the house surgeon when he came in. This patient is exhibited to show how deep septic inflammation can become. When this man was admitted the area of inflammation extended away over to the axilla on this side, and down to the other side there (indicating). The inflammation was so marked that when Dr. Heber opened it up he could cut the skin and this tissue here on the outside. The patient did not receive any anæsthetic at all, and seemed to be totally oblivious to the fact that we were cutting him at all. The probe would run practically down to the spinal column at the time. He also has been under the bromin treatment. The inflammation has gradually and steadily decreased, until now we have a granulating wound. He walked about for four days previous to coming in. He would saturate two or three undershirts. He thought it was simply a case of hives or some such thing as that when he came in.

CASE 6. *Fracture of Patella.*—The treatment of fracture of the patella varies according to the man. I believe at the present time it is quite the thing to cut down to get a transverse fracture. The plan is to cut down, remove the blood clot and sew up the capsule. Authorities differ as to the advisability of opening. This case was wired, and in wiring there was absolutely no inflammation, and the patient has got a good bony union. There are, of course, two ways of wiring the bone; one the subcutaneous, and the other, the open joint method. This was the open joint method. The wires have been removed and the patient has a good bony union. It is only ten days now since the wires were removed, so that she has not as yet much motion in the joint. The operation was three days after the injury.

W. H. PIERSON: May I say one word about kangaroo tendon in place of wire? A few months ago I used kangaroo tendon and closed the wound up. This necessitates, of course, re-opening and taking out the wires; and I am sure that my experience with one case was very gratifying, and I like it very much.

DR. WALMSLEY: You see, the incision is made longitudinally over the joint and then wired, the two halves wired together. Some authorities, such as Wyeth and one or two others, decry the opening up of the joint at all; say that it is wrong to do so, for the danger of infection. Wyeth speaks of one case where he got gangrene following the opening up of the joint.

CASE 7. *Tumefaction of the Breast.*—This case is a tumefaction of the breast, and there will be an operation shortly, but we show this for everyone to come in and get busy. The mother died in childbirth. Otherwise, no history obtainable. Father died of old age.

No history of carcinoma in any members of the family. Married at the age of 25. Has borne two children, neither of whom lived more than two weeks. No miscarriages. No specific history obtainable. Patient remarried within the last four years. No children from this union. Patient was admitted to the hospital on the advice of an outside physician. About one year previous to entrance to the hospital the patient experienced a sharp, stinging pain, which radiated from the right hand up the right arm, right breast, and two months after that the patient discovered a hard, firm lump at the right of the left nipple about the size of a walnut. Pains at this time, sharp and stinging in character and present both day and night, and almost continuous. Within two months the lump has enlarged to the present size, about that of a man's fist, and has since then shown practically no increase in size. Enlargement more to the right of the gland. Pains since then have been periodical, but present night and day. Small enlargement in right mammary gland. The patient was treated some time by an outside physician, who used internal treatment only. No result thus obtained. The patient gives us no history of traumatism. Nipple of right mammary gland involved was never developed, and in consequence the patient never allowed either of her two children to nurse from this breast. Left mammary gland is normal.

X-RAY AND ELECTRICAL CLINIC.

WILLIAM H. PRICE.

Dr. William H. Price showed cases of epithelioma that had been cured by the X-ray, and several nervous cases, including acute anterior poliomyelitis and multiple sclerosis, demonstrating the static machine, high frequency, X-ray and the use of faradic and galvanic currents.

MEDICAL CLINIC.

WILLIAM L. LOVE.

CASE I.—This is a case of psoriasis known as lepra vulgaris, otherwise dry or scaly tetter. Psoriasis is a non-contagious skin disease that develops originally in the extensor surfaces. The scalp and various other portions of the body may be involved. When the

scalp is involved, there is often a seborrhoic element. Psoriasis develops from an isolated spot known as psoriasis punctata. This spot gradually becomes covered with branny scales. Then it is known as psoriasis guttata. Gradually this enlarges and assumes the shape of a coin, when it is known as psoriasis nummularis. These round involvements coalesce and are known as psoriasis gyrata. When they assume the aggravated form they are known as psoriasis aggregata. We must differentiate psoriasis between seborrhoica, eczema, lichen planis, lupus erythematosus, syphilis and ring worm. The remedies most useful are sulphur, antimony and tartaricum, which is prescribed by Bulkley frequently in appreciable doses of one-sixth grain three times a day, calcarea carbonic, mezereum and arsenicum album. The latter remedy is probably the one homeopathic to the most cases. It is frequently given in the form of Fowler's solution, which is as homeopathic to many cases of psoriasis as is arsenica third, the remedy being the thing that is homeopathic, the dilution or trituration a matter of personal preference. The woman that I present before you shows the effect of treatment, and the scales are not as prominent as in the initial stages.

CASE 2.—I present to you a case of rodent ulcer in which there is a specific history. You will find a specific history attaching to a great many cases that we have here in the hospital, particularly the dermatological cases, and you must not always expect to find a history of syphilis in a syphilitic case. Many patients attempt to deceive a physician as to previous syphilitic infection, and we physicians should be constantly on our guard for such deception. Case two which I present to you is one of syphilitic gumma, which is a tertiary lesion of syphilis. The tubercular syphilid should not be confounded with tuberculosis, there being no connection whatever, the names being similar; but "tubercular" in this case simply means an elevated papule or tubercle. Syphilis is a contagious disease that is transmitted either by inoculation or heredity. The primary lesion of syphilis is chancre, which occurs on the mucous membrane of the part first affected. It is known as a hard sore, in contradistinction to the soft sore, which is known as a chancroid. The difference between chancre, which is the true primary lesion of syphilis, and chancroid, is as follows: The hard sore has a slight moisture attaching thereto. There is involvement of the glands of both sides. The sore is not autoinoculable, and appears anywhere from ten to a hundred days after exposure. In chancroid there are no constitutional manifestations. The sore comes from filth. It is autoinoculable. It is an ulcerated condition, soft, and may extend all around the penis. There may in this case also be involvement of the glands of one side, which may suppurate. The chancroid is self-limited. The chancre is followed by constitutional symptoms of syphilis, the rash, the eruption in the mouth, fever, malaisé, and finally, tertiary symptoms of syphilis affecting the bones and all

organs of the body. The tertiary stage of syphilis presents gummata, which are like tumors or sarcoma. The papular lesions of syphilis may be mistaken for psoriasis. The pustular are often mistaken for impetigo or pustular eczema. The secondary symptoms of syphilis are initiated by the appearance of the rash. This rash must be diagnosticated from measles and from German measles, and also from the drug eruption of copaiba and quinine.

ADDENDA.

To the list of contributors to the Legislative Fund (page 172) should be added, E. Wilton Brown, $5.00, and O. S. Ritch, $5.00. The ten dollars credited to F. W. Seward should read, F. W. Seward, $5.00, F. W. Seward, Jr., $5.00.

APPENDIX.

Necrologist's Report .....JOHN L. MOFFAT
Obituary of—
FRANK H. DE CAMP, M. D.
FRANCIS E. DOUGHTY, M. D.
JEROME B. LAWRENCE, M. D.
ALFRED J. BUTTERFIELD, M. D.
JOHN HAVILAND OTIS, M. D.
WILLIAM DE LA MONTANYE, M. D.
JAMES E. RUSSELL, M. D.
Biographical Sketch of PRESIDENT HERBERT DANA SCHENCK.
Circular Letters Issued by the Committee on Legislation.
Report of the Banquet with Post-Prandial Speeches.
Constitution and By-Laws.
Standing Resolutions.
Honorary Members.
Chronological Table of Officers.
Roll of Membership.
State Directory.
Openings for Practice.

Necrologist's Report.

FRANK H. DE CAMP, M. D.

Dr. F. H. DeCamp, who died at his home, 410 William St., Elmira, N. Y., of uræmia and pneumonia, on December 22, 1906, was a native of Newark, N. J., where he was graduated, with honors, from the Newark Academy is the class of '86. Dr. DeCamp was an alumnus of the New York Homeopathic Medical College and Hospital, of the class of '92. After one year in the dispensaries and hospitals of that city, he opened an office in Horseheads, N. Y., a suburb of Elmira, where he built up a lucrative practice. After eight years he opened an office in Elmira, also residing there, yet retaining the office in Horseheads as a branch. In Elmira his prac-

tice was large and growing, and he was regarded as one of the most faithful, conscientious and studious of medical practitioners, his specialty being women's and children's diseases. Dr. DeCamp was a staunch Homeopath, and was strongly opposed to any move that savored of diminishing the individuality of the new school of medicine. He was a member of the American Institute since 1902, of the New York State Homeopathic Medical Society since 1901, and of the Southern Tier Society; was also a member of the Unanimous Club of New York. Dr. DeCamp is survived by his father and mother, residents of East Orange, New Jersey, and by his wife.

FRANCIS E. DOUGHTY, M. D.

BY JOHN HUTCHINSON, M. D.

Dr. Francis E. Doughty became a member of this Society in 1877 and of the New York County Society in 1871, of which he was president during the years of 1883 and 1884. His birthplace was Troy, N. Y., his birthday August 14, 1847, and his ancestry was of the best New England stock. His earlier education was gained at New Haven, Conn., and Yonkers, N. Y. He graduated in literary and commercial collegiate courses in 1866. At this time he had a strong predilection for surgery. He therefore matriculated at the College of Physicians and Surgeons, New York city, and was graduated therefrom in 1869.

Dr. Doughty was appointed attending surgeon to the New York Homeopathic Dispensary, and later associate house physician to the institution. Soon afterward he was elected to the chair of Surgery in the New York Medical College and Hospital for Women, a position which he occupied for three years.

From 1872 until 1894 he filled the chair of Genito-Urinary diseases in the New York Homeopathic Medical College and Hospital, from which he resigned in the latter year to accept the professorship of Surgical Gynæcology. For fifteen years Dr. Doughty had also served the college as Professor of Anatomy.

The students who sat under Dr. Doughty were uniformly impressed with his directness and clearness of thought, and its presentation. He was an admirable teacher, and one who made the subject under consideration the only one for the hour.

Besides active duty in Hahnemann Hospital for twenty years, he served as attending surgeon to the Five Points House of Industry for the same period, giving much time and energy to this worthy cause.

Of the American Institute of Homeopathy, Dr. Doughy had been a senior member for several years, having joined that body in 1872. He was an active member of the Pathological and other local societies and clubs. At his death he was still consulting surgeon to Hahnemann, Flower, and Laura Franklin Hospitals.

He belonged to the Society of Mayflower descendants, the Society of the Colonial Wars, the St. Nicholas Society, and the New York Yacht and Fencers' Clubs.

The Doctor's contributions to medical literature were valuable, and they received distinctive recognition. A mind and judgment like his could not fail to inspire and maintain interest in any topic to which he devoted himself. The school of Homeopathic medicine sustains great loss in his removal from its ranks.

Dr. Doughty died at his late residence, 512 Madison Avenue, December 28, 1906, of pneumonia. His wife had passed away not many months ago. One daughter, the wife of Dr. Frederick Lund, is left.

JEROME B. LAWRENCE, M. D.

Dr. Jerome B. Lawrence was born in New York in the year 1846 and died in Brooklyn April 11, 1907.

Promptly on receiving the degree of M. D. at the New York Homeopathic Medical College and Hospital with the class of '85, he settled in Brooklyn and joined the Kings County Society on the 2d of June of the same year. In 1894 he became a member of this State Society. In religion he was a member of the Baptist Church.

Marrying Elizabeth Collamer in 1882, he was left a widower in '99, and later married Miss Annie Howard, who survives him.

ALFRED J. BUTTERFIELD, M. D.

Dr. Alfred J. Butterfield was born in Cortland County July 6, 1851. After attending the Dryden and Lisle academies, he studied medicine with Drs. Baker and Totman, of Syracuse, then went to Philadelphia, where he was graduated M. D. in 1872 by the University of Pennsylvania.

Following a five years' stay in Eldridge, Onondaga County, he studied the eye and ear at the New York Eye and Ear Infirmary, then went to Cincinnati and graduated at the Eclectic Institute.

After a year's practice in Syracuse, he went to Binghamton in 1881, but in 1887 was forced by ill health to give up active work for ten years. In '97 he returned and resumed practice, but for the last two years his health has been poor, confining him within doors since last fall. His death, April 18, 1907, was due to anæmia, brought on by steady application to his profession; the only vacations he took were those he was obliged to. March 25, 1873, he married Josephine Jennings, of Hartford, Cortland County, who survives him with two sons and two daughters. He was as regular an attendant at the First Congregational Church as his health permitted. He joined this State Society in 1903.

JOHN HAVILAND OTIS, M. D.

"Doctor John" Otis was born at Hart's Village, Dutchess County, July 27, 1871, the son of Dr. John C. and Katherine Haviland Otis; his parents moved to Poughkeepsie on the first day of the following year. His education was obtained at private schools Riverview Military Academy and the New York Homeopathic Medical College and Hospital; the latter graduating him M. D. in '92, after a four years' course. He immediately commenced practice with his father. In October, 1894, he married Miss Louise N. Smith, also of Poughkeepsie, who survives him with three children.

Dr. Otis paid special attention to diseases of children, taking a course in the New York Post-graduate almost every year. He joined this State Society in 1903; was president of the Dutchess County Homeopathic Medical Society, member of the Tricounty Homeopathic Medical Society, and of his medical college Alumni Association. He was also a Mason and Knight of Pythias, for several years attending physician at the City Home, and was one of the Charity Commissioners at the time of his death.

Repeated attacks of rheumatism culminated in valvular heart disease, which was troublesome for the last two years. Early in January a severe attack of grip disabled him, and he went south for several weeks; but the unprecedented heat there weakened him, and on his return serious liver and kidney complications supervened, from which he partially rallied; but the onset of extreme hot weather gradually reduced his strength, heart stimulants failed, and in the early morning of June 30, 1907, the end came.

WILLIAM DE LA MONTANYE, M. D.

Dr. William de la Montanye, at the time of his death—August 11, 1906,—the oldest physician, both in years and active practice, in Kingston, was born in 1837, graduated M. D. by the New York Homeopathic Medical College in '67 and joined this State Society in 1891. He located in Rondout after graduating, and married, November 3, 1870, Anna D. W. Smith, who survives him with one married daughter. He was a friend to everyone and physician and adviser to many.

JAMES E. RUSSELL, M. D.

Dr. James Edwin Russell was born in New York August 20, 1858, the son of Julia Marinette Hatch and Solomon Birdsall Russell. He attended public school and the College of the City of New York, receiving the latter's degree in 1876. Determining to study medicine, he took four years at the New York Homeopathic Medical College and Hospital, and graduated in its class of 1880.

He practiced a year in New York, five years in Denver, and in Brooklyn since 1887. In 1889 he joined the State Society. He was a member of the Episcopal Church, of the Royal Arcanum, and had been examiner for the American Legion of Honor. March 13, 1882, he married Miss Edith Katrina Singsen, of Monticello, N. Y., who survives him with a son and daughter.

Dr. Russell died July 21. 1907, of injuries at the hands of persons unknown.

BIOGRAPHICAL SKETCH

OF PRESIDENT HERBERT DANA SCHENCK, B. S., M. D., O. et A. Chir.

BY E. RODNEY FISKE, M. D.

The training of early life in the individual leaves its mark and distinctive elements, and it is through these revelations of personal characteristics that we recognize sturdy ancestry. This is all that progenitors can mean to the individual, the imprint of positive mental features and family proclivities. From his ancestry Dr. Schenck has received the benediction of distinct and positive characteristics. On his father's side he looks back for his mental inheritance to the Dutch settlers of New Holland, from his mother to the vigorous sea-faring people of New England. From the Dutch we see the origin of his patient perseverance and industry peculiar to those early settlers, from the Puritan maternal side, the unswerving devotion to duty and its conscientious performance; the integrity of purpose and stability of temperament, which are the special attributes of the president of this Society.

Born in Union Springs, on Cayuga Lake, New York, June 28, 1857, his early life was spent in this town where he was sent to school, first attending private classes and later the Union school. His father, Horace Schenck, and his mother, Sarah Schenck, were natives of this place and were descended from early settlers, his father being of Dutch origin, and his mother a descendant of New Bedford whalers.

After leaving the Union school, Dr. Schenck entered Oakwood Seminary and completed a course of instruction there. Soon after leaving this institution, he decided to enter Cornell University, and did so in 1878, graduating as Bachelor of Science in 1882. He attained high standing and the respect of his classmates and professors during his college career. Special preparatory study for medicine was taken in Professor Burt G. Wilder's laboratory in the field of comparative anatomy. This and other preliminary work enabled him to take an advanced place in the fall of 1882 in the New

York Medical College and Hospital. He maintained a high order of scholarship during his study of medicine, and on graduation in 1884 became resident physician at the Five Points House of Industry. Here he remained one year, while taking a course at the New York Ophthalmic Hospital, where he obtained the degree of O. et A. Chir. in 1885.

In looking for a place to practice his specialty, he followed the advice of the late Dr. W. M. L. Fiske to locate in Brooklyn. He settled there in 1885 and became identified with the Brooklyn E. D. Homeopathic Dispensary and gave prompt, regular and conscientious service to the Institution for many years.

He was married in the fall of 1885 to Miss Martha Marietta L'Hommedieu, of Union Springs, and located at 247 McDonough street, where he lived until 1904, when he moved to his present home and office, 75 Halsey street.

For the first years he had a daily clinic at the Eye and Ear Dispensary, and was also made visiting oculist and aurist to the Brooklyn Nursery and Infants Hospital.

He joined the Homeopathic Society of Kings County in March, 1886, and at the annual meeting in May following was elected secretary, a position he held for six years, relinquishing it to become president. Soon after he was elected visiting oculist and aurist to the Brooklyn Maternity Hospital and also held the same position at the Brooklyn Homeopathic Hospital.

He became secretary of the American Ophthalmological, Otological and Laryngological Society, which position he held four years, and became its president in 1904.

He joined the American Institute in 1894, and the New York State Society in 1898.

During these years of professional activity he has served times without number on important committees for all purposes, advancing the interest of his profession and in every instance has proven a wise counsellor, a faithful worker and an earnest advocate of homeopathic interests. His contributions to medical literature have been numerous and valuable. These have been made to his county, state and national societies.

He is a member of the University Club, of Brooklyn, in which he has taken an active and valued interest; the Cornell University Club of New York; he is president of the General Alumni Committee of Cornell University, and is an active member of many medical clubs in New York and Brooklyn.

Dr. Schenck combines in his character the charm of a pleasing address, the readiness of an enthusiastic friend and companion, the intelligence of careful and conscientious education, the well-balanced judgment of experience and foresight, the honesty and surety of upright principles, the consistent and unabating performance of duty to his friends and his profession.

CIRCULAR LETTERS

ISSUED BY THE LEGISLATIVE COMMITTEE, RELATING TO MEDICAL EXAMINING BOARDS AND FORMING PART OF THAT COMMITTEE'S REPORT TO THE SOCIETY.

CIRCULAR NO. 1.

(Sent to each Member of the State Legislature.)

To the Honorable Members of the Senate and Assembly:

The Legislative Committee of the Homeopathic Medical Society of the State of New York having been charged with the duty of protecting the interests of the Homeopathic Medical School, and deeming such interests jeopardized by a bill to be introduced into the Assembly, respectfully ask your careful attention to the enclosed statement of facts prepared by Dr. William H. Watson, a former Surgeon-General of the State of New York and a Regent of the University of the State of New York for a quarter of a century; a man who has deserved and received many other exceptional professional and civic honors, and whose opinions command the respect of every intelligent citizen of the State.

Dr. Watson expresses the concensus of opinion of the Homeopathic profession of the State, and fairly exemplifies the advanced medical thought and high educational standards which have characterized and still make this Empire State prominent before the world.

The enclosed reasons for maintenance of the separate examining boards law and for opposition to a single board bill are confidently submitted as rational, comprehensive and just.

Can the advocates of the single board bill give any cogent reason or show any real need for disturbing the present medical law, and incidentally precipitating a disagreeable medical fight?

It appears as if the single board agitation is brought forward at the instigation of some officials in the State Education Department as well as by the Allopathic School, and we venture to suggest, inasmuch as the State incurs no expense for maintenance of Homeopathic medical schools, and no expense for maintenance of the present three boards of medical examiners, the same being absolutely self-sustaining, it seems unjust—even impertinent—for the State Education Department to assume or undertake to acquire autocratic control of the State medical examining system.

It is claimed by the advocates of the single board bill that such legislation is necessary for the preservation of the present high

standard, and to prevent unqualified persons from assuming the rights which belong to educated practitioners of medicine. This point may be fully covered in a far more simple and easy manner by an amendment to the present law defining what constitutes the practice of medicine, and requiring every person who undertakes to care for the sick to meet the present requirements of the law.

In an effort to attain this result, a sub-committee from the legislative committee of the New York State Homeopathic Medical Society journeyed to Albany on New Years Day and held a conference over this matter with a sub-committee of the Allopathic Legislative Committee.

After considerable discussion, it was decided that the Homeopathic committee present at a later date an amendment to the present public health law, defining the practice of medicine. A draft of such an amendment was prepared, and on the 11th day of January, 1907, this committee, together with a similar committee from the Eclectic school, again visited the capital and presented to the Allopathic legislative committee an amendment which was agreed upon by the other two schools. The Allopathic committee said our amendment was no bill at all, and that the only terms on which it would confer was a single board bill without Homeopathic or Eclectic representation.

The present law was secured after a prolonged battle of eight years between the three schools, and there were only ten dissenting votes in both houses.

As you can readily see, the course of the Allopaths means annihilation of the Homeopathic and Eclectic schools. For this reason the legislative committees representing these two schools, who are now working unitedly for the maintenance of the present law, withdrew, and we now ask your honorable bodies, the Senate and Assembly, to permit no change in the present public health law unless it meets with the approval of the Homeopathic and Eclectic schools.

LEGISLATIVE COMMITTEE,
Representing the Eclectic Medical Society
of the State of New York,
LEE H. SMITH, M. D., *Chairman.*

LEGISLATIVE COMMITTEE,
Representing the Homeopathic Medical Society
of the State of New York,
JOHN M. LEE, M. D., *Chairman.*

CIRCULAR NO. 2.

(Sent to each Homœopathic Physician in the State.)

Dear Doctor:

The Legislative Committee of the Homeopathic Medical Society of the State of New York having been charged with the duty of protecting the interests of the Homeopathic Medical School, and deeming such interests jeopardized by a bill to be introduced into the Assembly, respectfully ask your careful attention to the enclosed statement of facts prepared by Dr. William H. Watson, a former Surgeon-General of the State of New York and a Regent of the University of the State of New York for a quarter of a century; a man who has deserved and received many other exceptional professional and civic honors, and whose opinions command the respect of every intelligent citizen of the State.

Dr. Watson expresses the concensus of opinion of the Homeopathic profession of the State, and fairly exemplifies the advanced medical thought and high educational standards which have characterized and still make this Empire State prominent before the world.

The enclosed reasons for maintenance of the separate examining boards law and for opposition to a single board bill are confidently submitted as rational, comprehensive and just.

Can the advocates of the single board bill give any cogent reason or show any real need for disturbing the present medical law, and incidentally precipitating a disagreeable medical fight?

It appears as if the single board agitation is brought forward at the instigation of some officials in the State Education Department as well as by the Allopathic school, and we venture to suggest, inasmuch as the State incurs no expense for maintenance of Homeopathic medical schools, and no expense for maintenance of the present three boards of medical examiners, the same being absolutely self-sustaining it seems unjust—even impertinent—for the State Education Department to assume or undertake to acquire autocratic control of the State medical examining system.

It is claimed by the advocates of the single board bill that such legislation is necessary for the preservation of the present high standard, and to prevent unqualified persons from assuming the rights which belong to educated practitioners of medicine. This point may be fully covered in a far more simple and easy manner by an amendment to the present law defining what constitutes the practice of medicine, and requiring every person who undertakes to care for the sick to meet the present requirements of the law.

In an effort to attain this result, a sub-committee from the legislative committee of the New York State Homeopathic Medical

Society journeyed to Albany on New Years Day and held a conference over this matter with a sub-committee of the Allopathic Legislative Committee.

After considerable discussion it was decided that the Homeopathic committee present at a later date an amendment to the present public health law defining the practice of medicine. A draft of such an amendment was prepared, and on the 11th day of January, 1907, this committee, together with a similar committee from the Eclectic school again visited the capital and presented to the Allopathic legislative committee an amendment which was agreed upon by the other two schools. The Allopathic committee said our amendment was no bill at all, and that the only terms on which it would confer was a single board bill without Homeopathic or Eclectic representation.

The present law was secured after a prolonged battle of eight years between the three schools, and there were only ten dissenting votes in both houses.

As you can readily see, the course of the Allopaths means annihilation of the Homeopathic and Eclectic schools. For this reason the legislative committees representing these two schools, who are now working unitedly for the maintenance of the present law, withdrew, and we now ask every doctor who receives a copy of this communication to immediately write strong letters to his Senators and Assemblymen, urging opposition to any change in the present medical law, and by all means induce every possible layman to do likewise. Do it now, before you leave your desk.

Another matter of unusual importance is the securing of students for the incoming class of the New York Homeopathic Medical College.

The Monroe County Homeopathic Medical Society, the Onondaga County Homeopathic Medical Society, the Medico-Chirurgical Society of Central New York, the Oswego County Homeopathic Medical Society and the Southern Tier Homeopathic Medical Society have all passed, unanimously, resolutions to the effect that every member of these societies endeavor to secure one or more students from the output of the High Schools and Colleges this summer as medical students.

As a matter of fact, since the old days of the preceptor have passed, material for all the colleges in the State has been lessened. Perhaps what we have lost in quantity has been gained in quality; but as we are unable to begin to fill all the places which desire Homeopathic physicians, it seems wise that more attention should be given to the securing of suitable students.

There are many Homeopathic physicians in the State who are not members of our State Society. Let all who receive this circular letter attend the next meeting at Albany on February 13th and 14th, and become members of our State Society which, more than all the other organizations, protects the Homeopathic interests of the peo-

ple and profession of the State. Matters of unusual interest and importance to the School will come up, and it is expected and earnestly desired that we have an exceptionally large attendance.

LEGISLATIVE COMMITTEE OF THE HOMEOPATHIC MEDICAL SOCIETY OF THE STATE OF NEW YORK.

JOHN M. LEE, M. D., *Chairman.*

Asa S. Crouch, M. D.	Geo. E. Gorham, M. D.
Jos. T. Cook, M. D.	O. E. Kinne, M. D.
DeWitt G. Wilcox, M. D.	W. F. Honan, M. D.
John W. LeSeur, M. D.	Wm. Tod Helmuth, M. D.
J. Willis Candee, M. D.	Wm. H. King, M. D.
Lynn A. Martin, M. D.	M. O. Terry, M. D.
F. W. Adriance, M. D.	Chas. Gennerich, M. D.
D. V. M. Hibbard, M. D.	Irving Townsend, M. D.
Wm. H. Watson, M. D.	Chas. E. Birch, M. D.
C. A. Albertson, M. D.	Wm. H. Hodge, M. D.
E. H. Wolcott, M. D.	D. H. Arthur, M. D.
Henry E. Merriam, M. D.	F. E. Wadhams, Esq.

CIRCULAR NO. 3.

(Sent to each Homœopathic Physician in the State.)

UTICA, N. Y., January 4, 1907.

DEAR SIR:

Permit me to direct your attention to a subject which is of the greatest importance to every Homeopathic physician in this State:

I allude to the attempt, made near the close of the last session of the Legislature, to abolish the now existing three State Medical Examining Boards and to substitue a single board for the whole medical profession.

To this action the Homeopathic physicians and their friends are unalterably opposed. My object in submitting the accompanying reasons for this opposition at the present time arises from the fact that it is understood that another *very objectionable bill* having the same ends in view, if not already introduced, will be presented at a very early period of the present session of the Legislature, and I wish to apprise you of the fact at the earliest possible moment.

The continuance of the existing separate examining boards involves the personal interest, present and prospective, of every Homeopathic physician in this State, hence each one can well afford to give to the subject his full quota of time, money and personal influence.

Every Homeopathic physician should consider himself *personally responsible* for the signal defeat of this measure. Unity of purpose and harmony of action, *promptly and continually put forth*, are essential to success.

This bill must be defeated in order to insure the perpetuity and permanence of the Homeopathic School and its institutions.

The attainment by the Allopathic of a *legal* supremacy over the Homeopathic School would inure to the permanent advantage of the former and to the permanent disadvantage, and, in the *end*, to the actual dismemberment of the Homeopathic School in this country.

Should the present movement succeed, the Allopathic School would surely *in the last analysis*, acquire and forever retain *a majority control* of the medical educational interests of this State. The conscious possession of irresponsible power, such as *a majority control by one school* in a *single* board provides, will *inevitably* lead to its abuse.

There are many and very cogent reasons for opposing a *single* board.

FIRST. The principle of minority representation and the principle of establishing *single* boards of medical examination in any State is *one* and *inseparable*.

In case there should be only *one* examining board, the question of *representation* of the different medical schools could *never* be *satisfactorily* adjusted.

The function of the examining board being administrative, the basis of representation thereon of the different schools should necessarily be *equal* in order to insure an impartial and just application of its judicial and executive powers. *Unequal* representation of the different schools in a *single* examining board would place a *premium on favoritism*.

The Allopathic School would never approve of a mixed board, *having equal representation*, for the obvious reason that the Homeopathic and Eclectic members, *by uniting*, would be able to assume control.

On the other hand, neither the Homeopathic or Eclectic physicians would approve the formation of any *single* board, *without equality of representation*.

The fact that the Allopathic School is concededly the largest, *should* give to it *no inherent right* in any way to limit or control the civil privileges of other schools or systems.

At the bar of public opinion, at least, it will stand on precisely the same basis as other schools of medicine.

SECOND. It would be impolitic and against public welfare to *force by law* a coalition, involving *important rival interests*, until there are evidences of greater harmony between the different schools than now exist.

THIRD. This law is proposed solely by the Allopathic School.

The people of the State do not desire it. The *single* board is not sought either by the Homeopathic or Eclectic Schools; on the contrary, it is *put forward by the Allopathic School against the unanimously expressed wishes of both the other schools.*

The *people*, on the contrary, have given us *separate* examining and licensing boards, and we desire to retain them.

After a severe struggle, lasting a quarter of a century during all of which extended period they were constantly opposed and hampered by the Allopathic School at every step, members of the Homeopathic School succeeded in placing upon the Statute book a law which is just and impartial to all, and we can never allow the three separate board system to be sacrificed at the behest of our ancient opponents.

FOURTH. The simple acceptance of minority representation in a single board would constitute a perpetual brand of inferiority and subserviency of action on the part of the Homeopathic members thereof.

The Homeopathic profession in this State will never consent to allow itself to be placed in such an embarrassing and disadvantageous position.

FIFTH. It will be noticed that the bill provides for the appointment of a board of nine members by the Regents, and that no reference is made to the different schools into which the medical profession is divided. It will therefore be discretionary with the Regents as to whether the Homeopathic and Eclectic Schools shall be recognized at all or not.

This provision affords no adequate protection against Allopathic control. It is, therefore, on account of its indefiniteness and uncertainty even more dangerous to the Homeopathic and Eclectic Schools than other modes of appointment.

SIXTH. The State, having vested in three separate schools the same civil rights, embracing those of organizing their own societies, hospitals and medical colleges, it would be an entire reversal of its established fair and impartial policy to prohibit each from licensing its own students.

SEVENTH. The establishing of a single board, controlled, in any degree by one school of medicine, would constitute class legislation of a most objectionable form.

EIGHTH. It is consonant with the recognized policy of this government to permit the members of organized bodies of its citizens entire freedom in the exercise of the civil right to perpetuate and maintain their respective associations.

NINTH. The licensing of medical students is a civil right, the exercise of which should be extended to the three schools equally.

TENTH. Because it is unwise, impolitic and unjust to deprive the Homeopathic School of the civil right to examine and license its own students.

ELEVENTH. Because it would be an act of as manifest injustice

to compel Homeopathic students to obtain a license from an Allopathic board as it would be to compel all applicants for religious orders to seek ordination from a board controlled by one particular religious denomination.

TWELFTH. The results obtained under the present law have fully demonstrated the wisdom of its framers. It furnishes abundant means by which the several schools of medicine are provided with examining boards of their own selection and placed wholly under their own control.

It is a good law—a satisfactory—law and while it confers no special or peculiar privileges upon any class of the community, it is one that by its liberal, impartial and entirely catholic provision has commended itself to the good sense of the people of this State. It is so administered that collusion, laxity or partiality is impossible. The possession of a license from the State Board of Examiners of New York is an assurance to the public of the qualification of him or her who shall attain it, and is therefore a legitimate passport to professional success. The archives of the University will forever attest to anyone interested, the exact tests relative to his or her professional knowledge applied in the examination of any man or woman who has earned its indorsement.

THIRTEENTH. If this movement is insisted upon by the Allopathic School, it will inevitably cause such a bitter and protracted contest between the school and other branches of the medical profession as has never yet been witnessed in this State.

Yours respectfully,

WILLIAM H. WATSON. (M. D.)

REPORT OF THE BANQUET

TENDERED TO THE MEMBERS OF THE STATE SOCIETY, AND THEIR WIVES, BY THE KINGS COUNTY HOMŒOPATHIC MEDICAL SOCIETY IN CELEBRATION OF THE SEMI-CENTENNIAL ANNIVERSARY OF THE LATTER SOCIETY.

About two hundred occupied seats at the tables in the banquet hall of The Assembly on Thursday evening, September 26th. Dr. W. W. Blackman, president of the Kings County Homeopathic Medical Society, presided as toastmaster. After dining, Dr. Herbert D. Schenck, President of the State Society responded to a toast to the State Society in remarks of appreciation and greeting. Similar speeches were made by President Royal S. Copeland, of Ann Arbor, for the American Institute and Ex-President Charles E. Walton, of Cincinnati. The following are several of the speeches in detail.

A RETROSPECT.

E. R. FISKE, M. D.

While visiting Pilgrim Hall, in Plymouth, I saw there the skeleton of a vessel that had been dug up on the Massachusetts coast about 1880. This vessel had been wrecked in 1626, six years after the arrival of the Mayflower. It resembled its predecessor in size and structure, so that it remains to-day a permanent model of the vessel of that period. Its size permits its storage in the cellar of the Pilgrim Hall, its length being much less than the width of that building—about forty feet. When we consider its size, and imagine it filled with daring and courageous pioneers, we are thrilled with awe and admiration for those men who entered an unknown sea and set foot on an inhospitable shore, in order that they might make personal liberty eternal and establish its everlasting truth.

To properly appreciate the early life of these pioneers and to realize the constant peril and sacrifice which they endured, one must have lived with them, and not afterward, when their courage and hardihood had insured and endowed the bounty of comfort and prosperity which we now enjoy.

The interest of our present celebration, therefore, may properly be directed with gratitude and respect toward the early life history of the pioneers of Homeopathy in this city. Their struggles for foothold entailed contempt, scorn, vituperation; and the arrows of professional venom lacked none of the sting and suffering caused by the shafts of the aboriginal enemies of the Pilgrim period.

The muse of History is a calm, cold unbiased woman, who tells no tales of fiction, and whose lyre is not tuned to mirth nor jest. Facts unvarnished make the subject of her canvas, and only rare artists like Gibbon, Hacaulaw or John Fiske can portray a glowing scene to hold the undivided attention.

I face, therefore, the actual story with much misgiving, knowing the difficulty in the situation. To paint the picture clearly we cannot gather our colors from the memories of those now living. We are fortunate, however, in having preserved to us a clear record written by Dr. R. C. Moffat, and presented October 13, 1864, as a paper to the New York State Homeopathic Medical Society, entitled "The Rise and Progress of Homeopathy in Kings County." Dr. Robert Rosman has the credit of being the pioneer in this county. He moved from Hudson, N. Y. to Brooklyn in 1840. He had become a convert to Homeopathy from the Old School, and left a good practice to come to Brooklyn. About five weeks after the appearance of Dr. Rosman, Dr. David Baker began practice in Myrtle Avenue and prospered. Through the exertions of these two pioneers, Homeopathy gained its first grip on the attention of the public.

In 1843 Dr. A. Cooke Hull came to Brooklyn as the partner of Dr. Rosman, and shortly after this time Dr. P. P. Wells came here from Providence, R. I.

In narrating his influence in the early struggles of Homeopathy in this city, we can point with pride to the brilliancy of his intellect and his courage in fighting for his convictions. I wish to quote from Dr. Moffat here:

"To him, too, necessarily fell the hard work of combating prejudices, withstanding obloquy and wresting triumphs in fields of his own making, for though the three years' labor of his predecessors had done something to make Homeopathy respectable, and to give it a name, yet in a wide city, numbering scores of thousands, the light of two practitioners could go out but a little way, and almost all beyond was darkness. Twenty years of activity have given him his reward, though long and hard earned. In the advocacy of pure Hahnemannian Homeopathy he stands pre-eminent in our midst; and in its practice none excel him in the discriminating precision of his selection."

Soon the efforts of the vigorous pioneers bore fruit in the public favor with which Homeopathy was received. Brooklyn, as well as other places, became the attractive place for young homeopathic physicians, and Williamsburgh, then a village, also appeared in the field.

For the five years following the coming of Dr. Wells, the growth was slow, but regular. Drs. Bennett, Guy, Burke, Moffat, Bryant, and Stansbury appeared from 1843 to 1850. Dr. Moffat relates an interesting occurrence about this time:

Drs. Hull and Wells, soon after their advent (1843), applied for

membership in the County Medical Society. They were, as they expected, promptly rejected because they were Homeopaths. Dr. Wells took the procedure as an expression of spite, but Dr. Hull proceeded to test the action legally. He had all the needful credentials and had complied with the required formalities. So he commenced a law suit to establish his right. This suit lasted sixteen years, and the highest court was reached in its decision.

The medical society was thoroughly beaten, and Dr. Hull had the satisfaction of receiving a letter, full of grace and courtesy, begging him to become a member of the Society.

In equal courtesy Dr. Hull declined, and shortly afterward became president of the Homeopathic Medical Society.

In 1854 a child, Agnes Lottimer, died from a recession of mumps under homeopathic treatment. Dissatisfied relatives, goaded by the Old School, had the coroner, Dr. Ball, a physician of venomous aspect towards Homeopathy, review the case, and the most formidable array of prominent and partisan physicians testified on the part of the prosecution. The object was to prove that the child died from neglect and error in diagnosis on the part of the homeopathic attendant. The defense adhered closely to the history of the case, and relied for its diagnosis on the best medical authors of the period. The jury reported in favor of the defendant, and removed all stigma from his name. These incidents simply illustrate the methods of the predominant school at that time.

In Williamsburgh the first homeopathic physician was Dr. George Cox. He was an English physician who came there in 1823. He became a convert to Homeopathy in 1841 to 1842. He was described by his former associates as a "melancholy apostate." He aroused the jealousy, hate, contempt and ridicule of his old friends, and was soon cut off from all professional intercourse. His personal popularity and his increased success in the practice of the art of prescribing, enabled him to defy the assaults of his enemies, and to turn his efforts into greater victories. He died amid great professional prosperity in November, 1853.

About 1845, Drs. S. C. Hanford, Egbert Guernsey, and W. A. M. Culbert, graduates of New York University, came to Williamsburgh. All practised Allopathy, but under the influence of Dr. Cox and the instruction of Dr. J. F. Gray, of New York, each became hearty converts in 1848.

Drs. Guernsey and Culbert soon after left Brooklyn, the former making a brilliant success in New York, and the latter in Newburgh.

In 1849 Dr. Albert Wright left Washington Co. N. Y., after a successful practice there of nineteen years, and came to New York to study Homeopathy.

Aided by the literature on the subject, and the teachings of Drs. Gray, Freeman and Kirby, he soon became a convert, and located in Williamsburgh with a successful and increasing practice.

In 1850 Dr. Jas. H. Ward and Dr. John Dickinson joined the

ranks, and in 1852 Dr. Wm. Wright followed his brother. Dr. Wm. H. Hanford, who is still living, also imitated his brother's example, and came to Brooklyn in 1853. Dr. Stamm arrived from Germany in this year, where he had been educated in the Homeopathic faith, and added greatly to the strength of the Williamsburgh practitioners.

In 1855 Brooklyn and Williamsburgh were consolidated, and the growth of the Homeopathic profession was continuous and rapid in the succeeding years.

In 1850 the first Homeopathic pharmacy was established by Mr. J. T. P. Smith near the city hall.

Twenty-five new practitioners were added in the next three or four years.

In 1853 the Brooklyn Homeopathic Dispensary was established at 50 Court St., and had distinguished citizens as its trustees, its president being the father of Dr. Carroll Dunham. One thousand one hundred prescriptions were made in the first year. In 1857 larger quarters were necessary, and the dispensary was moved to 83 Court St.

In 1855 the physicians in this city began a series of social meetings with one permanent officer, a secretary who acted also as treasurer and reporter. This association went through twenty-five meetings with well sustained interest. Theses, reports of cases, etc., form the body of the record. The last meeting was held September 3, 1857.

Dr. Moffat reported then that several homeopathic physicians in the city had been summoned by the Kings County Medical Society to appear before that body and show their diplomas, and prove their right to practice medicine, under threats of penalties in the event of disregard of the notice. It seemed, therefore, advisable to form a Homeopathic medical society in the county to give to the exponents of this school their rights and privileges.

A resolution introduced by Dr. Richardson and seconded by Dr. Minton read as follows:

Resolved, That it is expedient to take measures for the formation of a Kings County Medical Society in conformity with the law passed last April by the Legislature of New York.

Two weeks later another meeting took place, the necessary committees were formed, and a constitution was later adopted after careful preparation and revision.

On November 12, 1857, the Society was pronounced legally organized with twenty-two members. The Society began its career under the presidency of Dr. Eosman, the pioneer.

This, in brief, is the early history of Homeopathy in this city. Subsequent events include the advent of such men as Dr. T. L. Allen, Dr. Bernard Fincke, the establishment of our hospitals and dispensaries and the constant spread of the influence of the school to the present time.

Moses, in parting with the children of Israel, whom he had led through forty years of suffering and hardship in the desert, as he stood on the far side of the river Jordan, which he was destined never to cross, delivered to them a parting word of warning, as he looked over at the land flowing with milk and honey, the Promised Land for the chosen people. He told them that they were about to occupy homes which they had not built, to reap harvests which they had not sown, to own vineyards and orchards that they had not planted, and, in the towering eloquence which no man has ever surpassed, he begged his people to beware lest they forget their God and their duty to Him in the enjoyment of their great prosperity.

So may we be cautioned in our moment of prosperity, in these days when we are enjoying the fruits of our predecessors' sacrifices and energy, when Homeopathy is recognized throughout this community and retains its respect. Let us not forget the men who fought our first battles; let us not forget their devotion and steadfastness, and let us not forget to stand fast for our principles and continue to emulate our predecessors in advancing the cause of Homeopathy.

THE PIONEERS.

STUART CLOSE, M. D.

With the thought of the pioneers, there rises before the imagination a vision of the trackless forest, clothing mountain, hill and valley with primeval verdure; of mighty rivers having their source in some placid lake, or rising in bubbling springs and clear rivulets far up the mountain side, sweeping majestically onward toward the distant sea; of rugged rocks and dark ravines, where lurked the panther and the bear; of broad plains and sunny valleys, the homes and haunts of savage red men; of swamps, and hanging vines and lush grass; of noble trees towering above the surrounding forest, monarchs of a millenium of victorious struggles against tempest and tornado; but all in virgin state, untouched by the hand of civilized man. It is Nature, fresh from the hands of the Creator, stern but beautiful, cruel but full of promise; for Nature's opulence is man's opportunity.

Into this wilderness, gazing with historic eye, we see the coming of the pioneer, with his ox team, his rifle and his axe, ready to begin his struggle with the blind force of nature. His the task to wrest from the wilderness shelter and sustenance, while he clears his little field and builds his rude home in anticipation of the later coming of his family and friends. Rifle and trap and hook and line shall supply him with food and clothing until his corn and potatoes grow,

and a bark shanty shelter him until his log cabin is built in the midst of the little clearing beside the river. And when he has made the long trail back to civilization and his wife and children shall have returned with him, we see him again take up the struggle and carry it on until the fruitful years have brought the reward of courage and patience and skill, and we behold him surrounded by smiling fields and happy friends. The river has become a highway, bearing upon its bosom the products of a hundred farms. Upon its banks have sprung up villages and trading posts. Roads take the place of the blazed trail, and church and school house stand where not long before we saw only the log hut or bark shanty. The music of happy childish voices resounds, where but recently rang out the rifle shot and savage yell of Indian warfare, and every outward sign reveals the inward reign of peace and plenty.

Not to draw the analogy too fine, there is something akin to this in the records of pioneers in the world of ideas. Somewhat like this is the history of the pioneers of Homeopathy in the world, and the story of the pioneers of the Homeopathic Medical Society of the County of Kings, whose semi-centennial we celebrate to-night, shall serve to "point a moral and adorn a tale."

Whatever and wherever the field, the spirit of the pioneer is always the same. It is adventurous, sturdy, strong, patient, resourceful, self-reliant, dauntless. In this lies the inspiration of my topic. As we contemplate the character and lives of the men who exemplified these moral and spiritual traits, we are inspired and strengthened for the work in our own lives, for we, too, have opposition to melt and obstacles to overcome. The privation and hardship, the struggle and strife of pioneers in the material wilderness are paralleled in the world of thought. The inertia of inanimate nature finds its analogue in the mental apathy and passive resistance to new ideas of the unthinking masses. The active opposition, hostility and cruel warfare of animals and aborigines correspond to the bitter antagonism of those opponents of new ideas and methods who find their moral and pecuniary ascendency threatened by the vanguard of progress. The principles of progress are alike, and opulence, mental and material, is the common reward of success.

Into the wilderness of traditional medicine, toward the close of the eighteenth century penetrated the dauntless pioneer and heaven-inspired genius, Samuel Hahnemann, blazing the path soon to be trodden by many followers. Of his labors, trials and persecutions there is no need to speak. They constitute a chapter in the history of Homeopathy familiar to us all. In spite of strenuous opposition, his doctrine spread rapidly, and the close of the first quarter of the nineteenth century found the new school of medicine formally established in all the more important countries of Europe, with more than a hundred practitioners. Most of these had received their instruction either from Hahnemann himself, privately, or in the

school which he established in Leipsic in 1811, where he continued to lecture semi-weekly until 1821. The *Organon* has passed into its third edition, and had been translated into French, and the *Materia Medica Pura*, in six volumes, had reached a second edition. The press was beginning to disseminate the knowledge of the new mode of healing and report its wonderful cures. Royalty had patronized it, men of high standing had endorsed it, and among its students were many physicians of the old school and university graduates or students. Hahnemann himself had retired to Coethen under the fostering protection of the Grand Duke Frederick, there to complete, in peace and quiet, his great work, "The Chronic Diseases," and to carry on, largely by correspondence, a practice which extended to all parts of Europe.

Such was the state of Homeopathy of Europe in 1821. If any English-speaking people had heard of Homeopathy up to this time, they had shown no interest in it, nor any inclination to adopt it. The introduction of Homeopathy into America seems to have been entirely fortuitous, and yet in it we can see the hand of Divine Providence. There was no "long felt want" to be supplied, no urgent demand for change. The medical profession went placidly on, bleeding and purging its victims to untimely death. To the modest and retiring man who introduced Homeopathy in America there had come no vision in the night such as came to Paul in which " a man of Macedonia, standing, beseeched him, saying, Come over into Macedonia and help us." In 1825 Dr. Hans Burch Gram, an American by birth, a brilliant surgeon, physician and scholar, returned from Copenhagen, Denmark, the city of his adoption, to visit his brother, Neils B. Gram, in New York, where he resided. Dr. Gram had been educated in Copenhagen, and had attained eminence there as physician and surgeon. After holding numerous official positions in connection with the military hospital service, during the Napoleonic wars, and gaining the highest grade of merit in the Royal Academy of Surgery, he had acquired a competence for himself in private practice. During the years 1823 and 1824 he became acquainted with the principles of Homeopathy. He tested them in his own person and in private practice until he became convinced of their truth, and then formally adopted them. Having reached about his fortieth year, he desired to visit his family in America, from which he had been separated nearly twenty years. He reached New York some time in 1825. Through endorsing the notes of his brother, who was unfortunate in business, he lost his fortune and was compelled to resume the practice of medicine, under great disadvantages, in New York city. He was far too modest for his own good, and his English, after twenty years abroad, was bad. It was several years before his professional colleagues began to realize that he was a man of great ability. His first attempts to introduce the subject of Homeopathy were coldly received, and his pamphlet entitled "The Character of Homeopathy" made no impression.

Through his masonic affiliations, however, he became acquainted with influential men, and was then advanced to positions of influence. Among these men was Ferdinand L. Wilsey, a prominent merchant of New York, who became devotedly attached to Gram, and who subsequently became the first convert to Homeopathy in America, and the first American to practice Homeopathy. Wilsey induced his family physician, Dr. John F. Gray, to meet Gram, and in the discussions which followed, Gray became interested in Homeopathy. He permitted Gram to treat a number of chronic and difficult cases and closely watched the results. Marvelling at the brilliant cures, he began the study of the new method under Gram, adopted it in his practice, and became the leader of the little coterie of Hahnemannians which, under his powerful influence, soon began to gather. Thus, quietly, simply, naturally, almost as if by chance, was Homeopathy introduced into the new world. From such humble beginnings has grown the great institution of which we of the nineteenth century are so justly proud. To-day there are more than thirteen thousand homeopathic physicians practicing in the United States, including in their patronage a large proportion of the wealth and intelligence of the nation. Gram died February 13, 1840, after many months of suffering. Of him Gray said: "Wilson and I tenderly cared for him, and Curtis watched as a faithful son would a beloved father. He was an earnest Christian of the Swedenborgian faith, and a man of the most scrupulously pure and charitable life I have ever known. In the presence of want, sorrow and disease, secluded from all observation of the world, he ministered with angelic patience and earnestness."

Although modest and retiring, he possessed courage of the highest and most self-sacrificing type. It is related of him that once, while in Copenhagen, he was in attendance at an exhibition of a menagerie of wild animals, when a lion, enraged by the entrance of a drunken keeper into his cage, attacked the keeper and escaped through the open door of the cage into the arena. There was a cry and the crowd turned to fly. Gram, who was standing with a friend, eating a nut with a nut pick in his hand, instantly faced the lion, which was so near that Gram felt his hot breath. Gram's purpose was to plunge his hand with the nut pick into the lion's mouth, as the only way of averting the tragedy sure to follow, if he attempted to escape with those behind him. During the few moments while the lion hesitated, disconcerted by the intrepid bearing of the man confronting him, the attendants rushed up and secured him just as he was crouching for a spring. Thereupon Gram fell fainting to the ground. He did not recover from the effects of the shock for six months.

This act of Gram's has been said to show his fearlessness. Rather was it the act of a man who is constitutionally timid; of one who does know fear, but who possesses the higher moral courage and strength which enables him in moments of great danger, to rise

above all physical considerations and offer himself, a willing sacrifice, for the sake of others. It was the act of a true lover of humanity, for "greater love hath no man than this, that a man lay down his life for his friends."

In New York, at the time of Gram's death, there was a little group of able, earnest and enthusiastic followers of Hahnemann, of whom Drs. John F. Gray, Abraham D. Wilson, Amos Gerald Hull, Daniel E. Stearns, William Channing and Joseph T. Curtis were the most prominent. They were all men of broad education, ripe culture, and fine social standing. Channing was a cousin of William Ellery Channing, of Boston, the famous preacher and anti-slavery advocate.

It was in the spring of 1840 that Brooklyn received the first representative of the new art of medicine in the person of Dr. Robert Rosman, born in Claverack, Columbia County, N. Y., October 8, 1807. He graduated from the College of Physicians and Surgeons, New York, in 1830, and located at Hudson, N. Y. There, some time within the year, he became a convert to Homeopathy. Of the manner of his introduction and means of his conversion to Homeopathy so soon after his graduation from the collegiate stronghold of traditional medicine, there is no record extant. It would be interesting to know how, where, and of whom he learned the principles and methods of the new school. At this time there were less than twenty physicians practising Homeopathy in the State of New York, about half of whom were located in New York city. Doubtless he came in contact with some of the little group who were practising in New York city during his college course, and thus had his interest aroused. We may imagine the young man returning to his home in Hudson after his graduation, and spending the leisure which the young physician never lacks in his first post-gradute year, in diligent study of the *Organon* and *Materia Medica Pura*. As he feels the grip of the new principles upon his conscience, he realizes what their practice will mean. Alone, with no one to advise or aid him, and only a beginner, he feels his isolation. So the end of his first year finds him yielding to the irresistible desire for professional association, and returning to New York. Here he decided upon Brooklyn as being a new and promising field, near enough to New York to afford him opportunity for the counsel, instruction and moral support of his seniors across the East river. Such an interpretation of his motives and actions is consistent with his character, as subsequently developed and displayed, for while he was firm in his convictions, he was not of the militant disposition which characterized some of his sturdier contemporaries.

For a few months he was the sole representative of Homeopathy in Brooklyn. Then he was joined by Dr. David Baker (1840) who located in Myrtle avenue and began to build up an extensive practice, in which he continued until 1856, when, for domestic reasons, he sold out and moved away.

In 1841 Dr. George Coxe, of Williamsburgh, a physician of eighteen years' standing, announced his adoption of Homeopathy, and began its practice.

In 1843 Dr. A. Cooke Hull, a brother-in-law of Dr. John F. Gray, of New York, came to Brooklyn and formed a partnership with Dr. Rosman, which continued, however, only a short time. Although an able physician, he is better remembered for his extra professional activities. His civic pride and public spirit found expression in many ways, and Brooklyn owes him a debt of gratitude for his unselfish and far-sighted labors. It is principally to him and the intimate friends whom he enlisted, that we owe the existence of the Atheneum, the Philharmonic Society, the Art Association, the Historical Society, the Academy of Music, and the Kings County Homeopathic Medical Society.

Who can measure the extent of the influence for good of these institutions upon the social, æsthetic and ethical life of this great city? There were the enterprises to which he devoted much of his time and energy, and his success is the best criterion of his ability and popularity.

In December, 1843, Dr. Phineas Parkhurst Wells, the first Brooklyn physician destined to attain an international reputation, located here and began the practice which continued until his death, November 22, 1891.

These four men, Drs. Rosman, Baker, Hull and Wells, occupied the field in Brooklyn from 1843 to 1846, with Dr. Coxe in the neighboring town of Williamsburgh. During the next four years were added successively to the Brooklyn group, Drs. S. S. Guy, A. C. Burke, R. C. Moffat, Carroll Dunham, and J. Bryant, and Drs. S. C. Hanford, Egbert Guernsey, W. A. M. Culbert and John Young to the Williamsburgh group. Of the latter, however, Drs. Guernsey and Culbert remained only a few months, so that the year 1850 found Homeopathy with twelve representatives on this side of the East River. After this the growth of the school was rapid. By 1857 the number of practitioners had risen to thirty-six. New York city had at the same time ninety-three practitioners.

During this time old school opposition to Homeopathy had constantly increased. As Dr. R. C. Moffat said, "Prosperity, but not peace, was the lot of the pioneers. Their successes were such as could not fail to draw upon them the attention, and soon the envy and jealousy, of some who were quick to see that homeopathic extension meant allopathic decadence." This opposition, which at first merely took the form of professional disregard and ostracism, soon developed into active and malignant persecution. The law, then as now, required every physician to be a member of the county medical society where he resided; but it allowed the society to reject "unworthy applicants" by ballot. This afforded an opportunity which was quickly improved. Dr. Rosman had been admitted without question, but with the addition of two more able physicians and

the manifestly increasing public interest in the new system of treatment, the matter took on a different aspect. Drs. Hull and Wells were summoned to apply for membership in the county society, as the law required. When they presented themselves they were ignominiously rejected on the ground that they were Homeopathists. Dr. Wells coolly ignored the matter, and went his way alone; but Dr. Hull, knowing their legal rights and qualifications, and characteristically actuated by his never-failing public spirit, proceeded to test the matter in the courts. He brought a suit against the society to compel it to admit him, and won it. The society appealed and lost again. The case was contested and appealed again and again, until at the end of sixteen years the highest court was reached, and the society found itself a loser at every point with heavy bill of costs to pay. The doors of the society were then thrown open to the victors and they were invited to become members, but neither Dr. Cooke nor Dr. Wells accepted the invitation. In the meantime, another determined effort was made to destroy Homeopathy by means of a prosecution for malpractice, brought against a Homeopathic physician, under whose care a child had died from cerebral disease, consequent upon a retrocession of mumps. The highest authorities of the old school (Drs. Willard Parker, Joseph M. Smith, James R. Wood and Alonzo Clark) attempted to prove that the child died of neglected intermittent fever, denying that metastasis of mumps was a valid cause of death. The defense proved that the intermittent fever had disappeared under treatment, and showed by quotation from Schönlein and Rokitansky, accepted Allopathic authorities on pathology, that such metastasis of mumps was a possible and valid cause of death. The jury rendered a verdict for the defense, and Homeopathy once more triumphed.

Such experiences as these, together with the need and desire felt for a closer affiliation of the rapidly increasing number of homeopathicians, led to the formation of the Kings County Homeopathic Medical Society in 1855, the forerunner, by two years, of the present society.

The further history of the society is not in my province, and I return to the more personal phase of the subject in the delineation of the personalities of its most renowned members.

Wells, Dunham, Fincke—mighty trio! The life, the work and the personality of these illustrious men as members of the Kings County Homeopathic Medical Society are its crowning glory for the past and its highest inspiration for the future. Their names shed lustre upon the record of its existence. They were great men, each pre-eminent in his own sphere. The world has set the seal of immortality upon them, and crowned them with undying fame.

They towered above their fellows like the giant Sequoias in the forests of the Sierras, and shed their influence abroad in the world.

It is difficult for some of us to realize how great they were. "A prophet is not without honor, save in his own country, and in his

own house." Many whose privilege it was to sit with these men in the meetings of this society did not realize it. We were too near to see them in their true perspective. Most of us are more or less presbyopic when it comes to recognizing the talents of our neighbors. Too often we allow personal or selfish considerations to warp our judgment, and stand as a barrier between us and our highest good. False pride has kept many a young man from seeking that association with older and abler men in his own town which would have been freely granted him had he been willing to avail himself of it. Physicians from all parts of the world made pilgrimages to Brooklyn even within the period of my recollection, to do honor to Dr. Wells and Dr. Fincke, to seek the inspiration of their presence, and to glean a few grains of thought from their garnered stores of wisdom. Peers of Bönninghausen, Hering and Lippe, their writings were eagerly read and studied as they appeared in the periodical literature of the day, by men in all parts of the United States and Europe. Yet how few of us younger men in Brooklyn ever sought the fellowship which would have been so freely and glad-given to all who came in the right spirit. It was my high privilege to be on terms of intimate and affectionate fellowship with Dr. Wells and Dr. Fincke up to the time of their death, and I know how quick they were to welcome the young man who came to them for counsel, instruction or discussion. Especially true was this of Dr. Wells. The courtly grace and perfect kindness with which he welcomed such a caller was a revelation to one who had known him only on the floor of some of our society meetings. There, on occasion, he could be critical, severe, even scathing, in his denunciation of unhomeopathic practice, for it was that, more than anything else, which would arouse the fighting blood of the old warrior. He was a fighter, but a knightly fighter, "without fear and without reproach." Woe betide the unlucky wight who presumed in his presence to publicly assail or pervert the principles of pure Hahnemannian Homeopathy! Dr. Wells was down on him like a hawk swooping from the sky to pick up an unwary chicken. I can see the old man now, straighten up and hitch himself forward in his chair, his hands clasped tightly over the head of his cane, his keen gray eyes fixed intently upon the speaker, waiting impatiently until he should finish. Then, sometimes sitting, or rising and slowly drawing his tall and massive form to its full height, if the occasion were of sufficient importance, he would proceed quietly, incisively, mercilessly, to dissect the subject—and the speaker. When he had finished there was nothing more to say. There was nothing left but a few feathers to tell the tale and mark the spot! But in his own home, or in congenial public assembly, he was graciousness itself. No one who has experienced it will ever forget the gentle, persuasive pressure of his hand, as he almost insensibly drew one toward a seat near him and settled himself back in his big "gooseneck" rocker and opened the conversation. He was a good listener

as well as a good talker. Highly cultured by much reading, study and travel, he ornamented his discourse with apt illustration and telling incident. He loved a good story, and was quick at repartee. He was interested in many things besides medicine, and his principle criticism of one eminent man who came from Philadelphia to see him, was that he could talk of nothing but medicine. Dr. Wells took him for a drive in Prospect Park, pointing out its beauties. It was of no use. His guest was blind to it all, and would talk of nothing but medicine. Such a man, Dr. Wells said, was not truly great. A man who could not see and appreciate the beauties of nature and art, as displayed in our incomparable park, lacked the thought, something vital in his mental makeup. He took as much pleasure in the luscious "old master" which hung in his office, always attributed by him to the famous Italian sixteenth century painter, Guercino, and in his charming little female head by Huntington, as he did in effecting a cure on some seemingly hopeless case which had baffled the skill of many other good prescribers, or in flaying some homeopathic pretender. More than once he has called me to come and stand with him in silent admiration before the exquisite marble "Clyte" which stood on a pedestal before the mirror between the front windows of his parlor.

Very tender and gentle was he toward women and children, especially if they were sick. His presence always brought comfort and reassurance to the anxious and suffering to whom he administered. In spite of his seeming austerity, he was a man of delicate sentiment. He loved to be with beautiful and cultured women, and with bright and happy children. He loved flowers and trees, and birds and squirrels, and drove frequently in Prospect Park where he could enjoy them. Few things have touched me more deeply, and appealed to the best there is in me more strongly, than to come upon him in his office, as I have often done in the afternoon, and find him with a time-stained letter in his hand, reading it, while beside him on the table lay the little packet from which it was taken, tied with a faded ribbon. They were the early letters of his beautiful and accomplished wife, who preceded him many long years to the celestial home.

I speak of these things, in this presence, because we sometimes need to be reminded that a physician is first of all a man, and that to be a true and knightly man is our highest ideal. The knight of old was sworn to "protect the distressed, maintain the right, and live a stainless life," and when I can bring to you even a feeble sketch of such a man, as I have known him, in the person of one of our pioneers, I feel that I am worthily fulfilling my function on this occasion.

To Dr. Dunham, the lifelong intimate friend of Dr. Wells, was accorded, perhaps, a larger measure of personal loyalty, appreciation and honor than falls to the lot of most prophets in their own time and country. This was not only because of his brilliant attain-

ments as physician, scholar, writer and teacher, but because of his charming personality. He was cast in a gentler mold than Dr. Wells; was more affable, conciliatory, tactful in his professional and public relations. He had none of the occasional austerity of Dr. Wells. He was a better "mixer." He was magnetic, enthusiastic, but modest, a born leader of men, who thrilled under his eloquence or yielded to his powers of persuasion. His was a "sweet reasonableness and divine charity." He possessed the elements of popularity, in the best sense of the term, and he never used them unworthily. The profession delighted to honor him, and was nobly honored by him. His literary work, being more discoursive in style and more easily grasped, as to subject-matter, by the average man, than the work of Dr. Wells, had perhaps a larger circulation. After his death, reverent hands gathered his writings, published and unpublished, and gave them to the profession in book form, a precious legacy from one who had few peers and no superiors in his chosen line of thought and work. In this he was more fortunate than either Dr. Wells or Dr. Fincke. Would that the profession realized what it is losing in the failure, thus far, to do the same for them! If the papers and addresses of Dr. Wells were compiled and published, we would have the most valuable treatise on the principles and practice of Homeopathy that has ever been put forth. His practical papers on rheumatism, diarrhœa, intermittent fever and typhoid fever, which appeared in the *American Homeopathic Review*, and many others in the *Homeopathic Physician*, have never been equalled. For lucidity, comprehensiveness and true practicality, his didactic writings on the philosophy of Homeopathy are models of expression. His powers of analysis and clear, logical reasoning upon any subject connected with the practical side of Homeopathy were marvelous.

Dr. Fincke was the greatest savant, metaphysician and speculative philosopher our school has ever produced. He dealt with the deep things of science, as related to Homeopathy. He traveled the circle of the sciences in his search for confirmations, illustrations and extensions of the grand fundamental homeopathic principle, which he identified with the third Newtonian law of motion, and named the principle of Homososis, or universal assimilation. From Astronomy, Geology, Biology, Physics; from Geometry and the higher mathematics; from History, Theology, Philosophy and Psychology, he derived the material with which he reared the citadel of homeopathic science which was to be forever impregnable to all assaults.

He did more than any other man who has ever lived to elucidate the deep things of Homeopathy, especially in its basic correlation with other sciences, and on the abstruse subject of potentiation and the infinitesimal dose. His erudite work on "High Potencies," published in 1865, is a classic, known, unfortunately, to but few of our school.

As a thinker and philosopher, he ranks with the highest. It is not presumption to place his name beside the name of Newton, as one who has dealt exhaustively, and in some respects finally, with one of the profoundest subjects of human thought. Like all profound thinkers, Dr. Fincke's greatest influence has been upon the minds of other deep thinkers and advanced students. Most of his work is beyond the comprehension of the ordinary mind untrained in philosophic thought, but none the less has his influence made itself felt in the medical world, through the work of those who derived their inspiration and their highest conceptions from him.

The personality of Dr. Fincke was a singular one, understood by few. Living for many years the life of a recluse, he was almost unknown personally to the later members of the profession in Brooklyn. Few Brooklyn physicians visited the little old frame house in Livingstone street, although it was a Mecca for many of the most eminent physicians and scientists from abroad, who came to meet the man whose writings had been a revelation to them of profound truths in homeopathic science. But those who knew him loved him, for with all his profundity, he was as simple and guileless as a child. Modest, sensitive, retiring, he sought seclusion rather than publicity, in order that he might the better work out the great problems that engaged his attention. His was a reverent mind, bowing humbly before the still unexplored illimitable depths of the infinite unknown. He was deeply religious, and ardently patriotic, as an adopted son of our great Republic, whose flag he honored and whose founders he revered. In his life he honored the principles and in his death he exemplified the beauty of the divine law of cure enunciated by Samuel Hahnemann. Dying, he was "like one that wraps the drapery of his couch about him, and lies down to pleasant dreams."

Another personality among the pioneers which stands out strongly in my memory, as it must in the memory of all of you who knew him, was that of Dr. Reuben Curtis Moffat, a pupil of Gram, and a long-time friend and associate of Curtis. Of large frame and courtly presence, he carried himself with great ease and dignity. Upon his smooth-shaven face he bore an expression of calm benignity. The gentle pressure of his large, white hand was reassuring. Always in full dress, with swallow-tail coat, broad expanse of snowy linen and immaculate white tie, and the elegant manners of the fine gentleman of the old school, he seemed to me the last connecting link between the bygone days of knee breeches, silver shoe buckles and powdered wigs, and the present day of such sartorial atrocities as tuxedos, "derbies," and tan shoes. He was the personification of exquisite and formal neatness and precision.

He was fluent of speech and ready in debate or discussion, in which he always conformed precisely to the strictest rules of parliamentary usage. He bore with perfect equanimity the delicate raillery to which Dr. Wells sometimes subjected him. He wielded

a facile pen, and contributed much interesting matter to the literature of our school. He was particularly happy in reminiscence, and his historical paper on "The Rise and Progress of Homeopathy in Brooklyn," presented in 1864 to the New York State Homeopathic Society, is a classic of its kind. I am indebted to it for many of the facts used in the preparation of this address. He was charitable, and devoted much of his time to work in charitable institutions, many of which he helped to organize and conduct, and to the last he was active in every good work for the advancement of Homeopathy.

"He was a man, take him for all in all,
I shall not look upon his like again."

There were others of whom I would speak a winged word. There was Joel Bryant (1850), patient sufferer, but loyal worker, in spite of great physical infirmity, who gave us his valuable "Pocket Manual;" Edwin A. Lodge (1853), later the able editor of *The American Homeopathic Observer*, of Detroit; J. Pitman Dinsmore (1853), who removed to San Francisco, attained eminence, retired to beautiful Napa Valley, California, where he married my widowed mother and became successively my step-father, physician, preceptor, "guide, philosopher and friend," the while he drilled me in the precepts of the *Organon;* Joel Barker (1853), "next to Henry Ward Beecher, the most popular man in Brooklyn;" Henry Minton (1853), loyal Hahnemannian and indefatigable worker; "the woman's friend," who gave us his invaluable "Uterine Therapeutics;" Joseph B. Elliott (1854), direct descendant in the seventh generation of John Elliott, the beloved "Apostle to the Indians," friend and disciple of Hull and Wells, true physician and gentleman; and last, but not least, faithful old J. T. P. Smith, who in 1850 established the first Homeopathic pharmacy, and aided greatly in the extension of Homeopathy in its early days.

Such were our pioneers. We glory in their character and their attainments. Their lives and examples are ever before us as our inspiration. What we are to-day as a school and as a society, we owe to their courage and to their devoted labors. The paths which they blazed through the wilderness we have broadened into highways whereon all who will may travel in comfort and safety. The cup which they have kissed we raise to-night, filled to the brim with the wine of gladness and thanksgiving, and, drinking, bid them Hail and Goodnight.

THE INFLUENCE OF HOMŒOPATHY UPON GENERAL MEDICINE.

JOHN E. WILSON, M. D.

I have been asked to say a few words concerning the effects which Homeopathy has produced upon general medicine. It is easy to talk upon such a subject, for in a certain way a doctor considers that question every time that he has the charge of a very sick patient. In such a case, he asks himself, over and over again, "Am I doing the best that can be done for this person? Could another man do better?" No matter how commercial a man's instincts may be, the presence of great suffering wakes conscience in us all. We, then, from our interests and moral responsibility, are practically meeting this question every day of our lives. It is very difficult to estimate the value of the therapeutic element in the success of any given physician. So much depends upon the environment of his clientele, so much upon his knowledge of hygiene, both physical and mental, and so much upon his own personality. On account of these difficulties surrounding the practice of medicine, I have decided to give you my opinions, simply as my opinions, founded on my own experience and my observation of that of others. One night, a school-master in a small town in Maine, stole quietly into the room of a favorite pupil who was very ill. On gently opening the door, he was very much surprised to see the object of his solicitude down upon his knees by the hearth, from which he had removed a loose brick. He next saw him pour into the aperture part of the contents of a bottle which he had in his hand, and then, replacing the brick, start to crawl back to bed, when he perceived the teacher. Being asked to explain, he said, "That hole has taken a lot of my medicine, and I guess it will take a lot more before I get well." The remedy was so nauseous, that the boy, whenever opportunity offered, had dragged himself from his bed and poured it down that hole, rather than take it. Many a case, before and after this one, has had remedies as nauseating, but had neither the strength of body, nor the ingenuity of mind of that boy, and has died from repugnance to the remedy, or a sheer inability to take it. The little medicine case going into a single house has, in the long run, lightened the trials of every invalid on that street. Our doctors nowadays give tablets, concentrated drugs, or palatable mixtures of one sort or another. Our competition has been a factor in producing this change, and it seems to me a very considerable one. If one doubts this, let him study the methods of the doctor in England, or on the Continent, where Homeopathy is still a negligible quantity. On the last day of a long and stormy voyage, I met upon the deck a lady with whom

I was acquainted, but whom I had not known to be on the ship. On meeting her, I asked her if she had just come aboard. "Not I," said she, "for I can hardly walk, let alone swim." I said, "Where have you been?" "In my stateroom," said she, "and I have nearly died." "Of what were you dying?" I asked. "I don't know," said she, and then told me the whole story. It seems she felt ill on coming aboard, and so she called the ship's doctor, who was an Englishman. He examined her, and said that she had bronchitis, and told her that he would send her a draught, which promptly came. This draught was about a half a pint in quantity, and to be taken at one dose, as the name implied. It was as potent in quality as it was generous in quantity, and, after the dose, she said that she was dead to the world for the next twenty-four hours. At the expiration of that time he called again, and repeated the prescription. This went on from day to day, until she finally plucked up her courage to the point of sending word that she had been treated sufficiently, and at last made a recovery. When I left her, she was still undecided in her mind as to whether she had had bronchitis, had been seasick, or had succumbed to the vigor of English therapeusis.

We have been called symptom-hunters, and our method has been unfavorably compared to that system which physiologically antidotes the pathological changes supposably discovered in the body. Ultimately, all cures may be produced by the action of anti-toxins, and medicine, as we use the term, may be thrown upon the heap of the world's discards; but it is not yet true. The world is full of new theories which are the result of painstaking and self-denying labor. They seem to be true, still most of them don't work, and we are often forced to take the attitude of a certain eminent London physician. There was a meeting in London, where the physiological chemists proved that one after another of the classical stomachics possessed no power to promote digestion. This physician finally arose and said, "Gentlemen, I admire your industry, and cannot find a flaw in your processes, but my patients, in defiance of science, do better on bitters, and they will still get bitters." Anti-toxins have claimed their field, and other theories have made some of their claims good, but Homeopathy is not yet bereft of all her jewels, like a certain young Irishman, who one stormy winter's night applied for shelter at a police station. Just as he was turning to go down to the cells, the attention of the sergeant was directed to his deeply-seamed face. "What happened to you, my man," said he, "did you have the small-pox, or did some one throw you into a keg of nails when you were a tender infant?" "Mine is a sad story," said the man. "I was the prettiest babe in all Ireland, but my father, being a man of great wealth, thought the plain, natural charms were not enough for his heir, and therefore he had my face set with jewels, diamonds and rubies, and sapphires, and all manner of precious stones. Thus, I was the wonder of all Ireland until, when I was about twelve years of age, he had used up all his money in trying

to free old Ireland; then we had hard times, and the family would have starved except for the wealth in my face. First they took out a diamond, and then another, and then a ruby, and then a sapphire, until finally, as time went on, I was left as I am now, with only a carbuncle in the back of my neck." In spite of all revolutionary advances, mankind is still seeking a balm in Gilead for pretty much the same old catalogue of woes, and doctors must still prescribe. That is the fact; the only question is one of method.

When grippe first appeared as an epidemic in the late '80's, it was, as is usual in the early years of a long-continued epidemic, simple in type, and severe in symptoms. This is an especially fair field for the comparison of efficiency in the same disease, since the diagnosis was not in doubt. The patient knew when he was sick, for one attacked by the grippe in those early days was an invalid, and that "plumb immediate." At that time I was cognizant of the pathological history of a population of about 300,000. In the beginning, few physicians knew the pathology, or clinical history of the disease with which they were confronted. The Old School gave antipyrine by the ton, and howled for more, while the Homeopathist gave the indicated remedy and by as much as he was loyal to his creed, and skillful in his selection, by so much did his mortality record approach the vanishing point. Practically the only cases lost by men of my acquaintance were the old, or very infirm, and some did not lose even those. All this is true, but the funerals filled every street. The next year the undertakers bought new houses, the druggists all took European trips, and gave costly presents to the Old School doctors at the blessed Christmas-tide; but queerly enough, they would hardly recognize a Homeopath on the street.

Right here is the place to touch upon the potency of our drugs. In this same epidemic of grippe, it was very noticeable that our convalescents were remarkably free from the after-effects of the disease, while the contrary was true of the patients treated by other methods. Reduce this to its pathological terms, and any jury of medical men would have to declare that the blood of our patients was quickly freed from toxins, while that of the other patients was still in a deteriorated condition. If that means anything, it demonstrates that by our system of symptomatological prescription we are able to select a remedy for a condition of unknown pathology, which will specifically attack the infective micro-organism. I do not believe that the finite mind works with sufficient accuracy to make probable a homeopathic cure for every malady; I do not believe that it can antagonize every infection, and I am willing to acknowledge that there are cases and conditions where its application is very difficult, and perhaps utterly impossible. The belief which I wish to emphasize in this: Our remedies have been potent to jugulate many an infection, have put to naught the classical prognosis in many conditions, and more than this, I believe, speaking broadly, that taking a period of ten years, the patrons of a competent Home-

opathic physician (rather incompetent, if you wish) will not suffer over one-half the days of disabling illness that they will under any other variety of therapeusis. This is my answer to the question, "Which is the better, symptomatological or physiological prescribing?"

Hahnemann announced a theory of potentization by dilution and succussion, and though he was not able to accurately define its laws and limits, it has made possible much of our success in the past, and some of the apparent advances of the present look to this for their inspiration. Not long ago one of our number cured with lycopodium a case of gastric disease, pronounced by experts of the Old School to be beyond the power of medicine. It certainly is not potent unless changed by some means. Robin, of Paris, has applied it to the metals, long considered inert, and now the faculty of ultra-conservative France is acknowledging that there is some field, at least, for potentization by subdivision. Hahnemann annouced that, in some cases, a reduction of the dose to the infinitesimal was an essential for its curative action. Von Behring said, within a short time, "Call me a Homeopath, or not, I tell you that the success of anti-toxins depends upon the fact that the substance becomes curative only after infinitesimal dilution.

Now, gentlemen, believing as I do, what I have been saying, I claim that the effect of Homeopathy upon general medicine in the past has been to largely reduce the average duration of disease; that it has reduced the duration of convalescence after some of the grave infections, that it has safe-guarded and reduced the discomfort of tens of thousands who have never taken a dose of Homeopathic medicine in their lives; that it has brought principles to light which have not only been of tremendous value to the world in the past, but whose previous value may prove to have been only a faint adumbration of their potency in the future.

THE FUTURE OF HOMŒOPATHY.

BY DEWITT G. WILCOX, M. D.

After being assigned a toast, the solution of which is fraught with imponderable obstacles, I feel that I should much prefer to speak on the subject, "The Future of our Toastmaster," and then proceed to prepare a future for him commensurate with his crime. If fools rush in where angels fear to tread, you will here observe (if I attempt to picture the future of Homeopathy) a case where a tenderfoot was pushed in by a band of confederated angels just for the fun of seeing him get roasted. But if it is decreed that I must get my tender wings burned (you will here observe that I have changed

the metaphor from a tenderfoot to a moth, because I always feel more at home with wings than I do with feet), I am delighted to burn my wings in the light of this brilliant audience.

The foregoing remarks are made simply for the purpose of letting you know that this subject was not of my own choosing, but, like the greatness of Roosevelt and Porter, it was thrust upon me.

In the majority of instances the great work accomplished by any one man has, in the course of time, been superseded by work so vastly superior that the original work seemed small by comparison; but the pioneer is none the less honored, even though the advancement of science has absolutely overshadowed his work. Had the world been content with Fulton's first steamboat, our giant leviathans of the sea would never have been born. Had it also been content with Stevenson's puny little steam locomotive, we would not be traveling to-day at fifty miles an hour and getting smashed to pieces at the rate of one hundred thousand lives per year.

How useless would Franklin's electricity be to us unless supplemented by those gigantic discoveries, which have made this potential force our obedient servant? There seems to be in the minds of many of our old, tried and true practitioners of Homeopathy, an idea that there has not been and never will be any progress in medicine worth considering, unless foreshadowed by Hahnemann. Such men, we know, have ceased to be useful in the furtherance of medical thought. Hahnemann himself, would, were he living to-day, look upon them as hopeless. Before we predict with any degree of certainty, the future of Homeopathy, we must know as definitely as possible where Homeopathy stands in the light of present-day therapeutics; and we must not shirk the responsibility of looking at the situation squarely, not deceiving ourselves or our enemies.

To say that Homeopathy is all there is in medicine to-day, is magnifying the truth about tenfold. Hahnemann gave us a law by which we are enabled to treat successfully a *certain number* of diseases by internal medicine. Time and experience have demonstrated that we are not enabled to treat successfully all diseases by that method; neither is that method the only one by which we can successfully treat diseases. The fact that medical science has so far progressed since Hahnemann's time as to show us a quicker and more effectual method of eradicating certain diseases, is no discredit to Homeopathy, for Homeopathy is and always has been, and I think always will be, the only true science for the selection of a remedy for such diseases as are amenable to internal treatment.

There are a few (and God save the few) Homeopaths who yet think that any method of treating the sick which is not founded on the law of similars, or was discovered or devised by any man, woman or child who was not a Homeopath, is the work of the devil, and they will none of it. That sort of bigotry and littleness is as bad, or worse, than that which emanated from the Old School years ago.

How ridiculous it would have been for Fariday to have said,

because Franklin did not discover the induced current, "therefore, it would be heresy for any other man to attempt to discover it," or for future generations to say, "Because Fariday did not predict the telephone, the telegraph and the electric light, therefore those discoveries are to be discredited."

The Homeopath is a physician in the broadest sense of the word, and because he is a physician he should embrace every new discovery which scientific investigators have proven of value, whether that discovery is a new drug or a new method of preventing disease; and the Homeopath who does not do that, is unworthy of his calling. But, what is the result of this attitude on the part of the Homeopaths? The answer which the extremists or prejudiced Homeopath makes, is that we are retrograding and forgetting the teachings of our forefathers, and will be cut down by the Philistines. God grant that we are forgetting some of the teachings of our medical forefathers, for we older men have as much to forget in medicine as we have to learn. It's a case of Bill Nye's "Better not know so much," etc.

In mountain climbing we can best realize our progress by occasional stops for retrospection. Suppose to-night we stop and look back over our trail. Twenty-five years ago I recall that my old preceptor sat up all night upon one occasion, searching his Materia Medica for a remedy that was a similimum to puerperal fever. The patient had chills alternating with fever, sweats, foul lochia, tender fundus, hot skin, and a whole lot of other symptoms, which he had minutely recorded for his guide in selecting a remedy, and I recall that he devoured some two or three materia medicas that night in his frantic search for a similimum; and when he thought he had found it, he rushed off at early dawn to the patient's house, assured that he was going to cure her; then he went about his day's work, and came home at night, only to find the undertaker waiting for him to sign the death certificate. Could that good old doctor have had then that scientific knowledge of puerperal fever which medical science has since given us, he need only to have washed his infected hands before he went to the birth chamber, and the remedy would have been found. There would then have been no midnight candles, no tired doctor awake, nor a wake and candles at the patient's house. Which is more scientific, to find a similimum for a disease which could have been prevented, or to possess a knowledge, the use of which precludes the possibility of the disease? How many up-to-date homeopathic physicians depend entirely upon a remedy for puerperal fever? Do not they all seek to combat it by mechanical means?

We would not think of prescribing a remedy for the fever produced by the lodgement in the body of a poisoned arrow-head, until we had first plucked out the arrow-head. If we had no way of knowing that such a thing was lodged in the body, we might be excused for depending upon an internal remedy to cure the patient.

But if medical science had taught us definitely how to recognize the sign and symptoms of a poisoned arrow-head in the body, then it would be criminal for us to depend upon the action of our internal remedy to eliminate. Why? Because of the tremendous risk to the patient in thus waiting; and second, because of the prolonged and unnecessary invalidism. What is true of the poisoned arrow-head is true of all infective diseases, which can be eradicated by chemical or mechanical means.

It is but a few years since our devoted practitioners of Homeopathy burned the midnight oil and spasmodically spit tobacco juice on the bare floor of the country office, trying to find a remedy which would hurry the ripening process of a boil, or head off a carbuncle; and I am convinced that had the doctor himself been obliged to sit upon that boil while hunting for a similimum, there would have been an earlier solution of the problem of suppuration and auto-infection.

One of the most ridiculous articles which I have seen in a medical journal for years, appeared recently in a small homeopathic journal, issued in the interest of a drug house, on the subject of "Suppuration." It is ridiculous because so absolutely at variance with the well-nigh universally accepted theory of infection and its method of cure. But the writer seemed to think that he was excusable in making an ass of himself, so long as he was strictly homeopathic. He went back to the days of our forefathers, and tried to classify pus. You might as well try to classify liars, and after you had divided them into a dozen classes and minutely defined each class, wind up with two general divisions—liars and damned liars. The writer laboriously told how to select the proper internal remedy for laudable pus, sanious pus, ichorious pus, fetid pus, malignant pus, greenish pus, profuse pus, scanty pus, tardy pus, early pus, late pus, brunette pus, blonde pus, pus with hare-lip and bald-headed pus, etc. And when he had finished, I exclaimed, "God hel-pus."

The medical man to-day, who does not recognize the simple fact that "Pus is pus," just the same as "Pigs is pigs," and the one and only treatment for pus, no matter where located, is to evacuate it, ought to go back to the farm. Here again comes the arrow-head simile: remove it and get out the pus; then give your indicated remedy.

We used to think that the having of one boil necessarily meant raising a family of seven boils; but we have since learned that having boils and having children is different. You don't need to have more than one boil if you don't want to. You know, we used to give remedies to head off the fourth, fifth, sixth and seventh boil, and when our patient stopped at the fifth, we felt proud to think we had two to our credit. I don't know that it was any more comforting to have those two boils to look forward to than to look back upon. Personally, I think it was worse to have them behind. It is just a question of thorough eradication of the primary abscess, which prevents others following, and internal remedies will have

little effect in preventing further abscesses until the original distributing center is eradicated. Then overcome the effects with the homeopathic remedy.

Just the same in carbuncle. You can cut its life short many weeks by eradicating the hundreds of distributing centres colonized around the parent infective nidus, or you can let it run for months, and finally bury it with the patient by trusting to internal medicine alone.

Just a few more examples of infective diseases to illustrate the necessity of removing the source first and applying the remedy afterward. Take cholera infantum and other infective diseases of the alimentary tract. How diligently we used to study our materia medica to find the exact similimum to fit the cases of these little sufferers, and how many times it apparently did not fit. The law was not at fault; we had not given the law a chance. We were handicapping the indicated remedy with a poisoned arrow-head, and then wondered why it did not work. Now, we know that the disease is an infection, an auto-intoxication, produced from food ferments, and the rational thing to do is to cleanse the intestinal tract, where the poison lies, and then guard against introducing more poison by way of the mouth. So, again, instead of *burning* the midnight oil, we *sterilize* it, and with it lubricate the colon tube, wherewith to irrigate the infected bowel, and what is the result? We lose about one case of cholera infantum by this method, where we formerly lost three by internal medicine alone.

Take again, as an example, stomach pain. I presume more time and brain power has been expended in studying the materia medica, to find a remedy to control pain in the stomach, than any other one condition; and every man knows that he failed frequently to control it. We know now that pain in the stomach may mean serious disease, or it may mean simple indigestion, and our first duty is to diagnose it, not hunt for the similimum; and when I say that, I mean to know if it is an arrow-head or a functional derangement. We know that persistent pain in the stomach means, in seventy-five per cent. of cases, either gastric ulcer, gall bladder disease or cancer. Dr. C. H. Mayo says you might as well try to cure a varicose ulcer by pouring talcum powder down your trousers' leg, and expect it to stick to the sore, as to cure gastric ulcer with internal medicine. We can cure gastric ulcer by diet, hygienic treatment and surgery, but I seriously doubt if it were ever done by medicine alone.

In gall-stone colic and cholecystitis we again have the arrow-head, and our general practitioners recognize that they can cure their patients quicker, surer and more effectually by first having the gall stones removed and the gall bladder made sterile.

In the treatment of pulmonary tuberculosis, how much more are we relying upon fresh air, sunlight, diet, climate and environment than upon internal medicine alone. Is it not the same in typhoid,

where diet and nursing have supplemented medicine to a great extent? Are we prepared to prove that our homeopathic remedies have to their credit the percentage of cures in diphtheria that antitoxin has? If not, it is our duty to use it, and not lose time with remedies. Are we curing cancer, locomotor ataxia, epilepsy and paralysis with the homeopathic remedy? If not, have we a complete system of cure? We may in time, but until we do, we must not claim too much.

Will it be any discredit to the memory of Stevenson, who invented the steam engine, that his invention will gradually be replaced by the electric motor? Will Watts, the discoverer of steam, be any the less renowned because electricity is taking the place of steam? It is simply the inevitable progress of science, which supersedes one great discovery by another.

The homeopathic law was the most scientific law ever evolved for the selection of a remedy for a diseased condition, as disease was *understood one hundred years ago*, but it is no discredit to Hahnemann, or to his devoted and painstaking followers, that medical science has so far advanced that we are able to recognize the arrow-head upon the first symptom of fever and, by its removal, cure the patient without any medicine, and with infinitely less risk to the patient and a shorter period of invalidism.

We are, to my mind, entering an era of new medicine, not the product of any one school, but the logical outgrowth of scientific research along all lines of life and health; and the movement is too gigantic to be stopped or stayed by a difference of opinion upon the size of a dose or method of administration. Homeopathy and the homeopathic physician have been potent factors in bringing about this new era; but, gentlemen, we have got to get into the band-wagon of progress, or walk; and unless we do get in we have no right to complain because the old school holds the reins and pounds the bass drum. We can have our place on the front seat and hold some of the ribbons, if we get on and make a place for ourselves; but we will be everlastingly crushed if we try to walk along the sides and grasp the spokes, with the intention of holding back the band-wagon of progress.

Allopathic therapeutics has made a dismal failure for itself. The leading men of the old school frankly acknowledge that their system of internal medicine is in a state of therapeutic nihilism or chaos. Homeopathy has made a brilliant success and demonstrated her superiority to all systems of internal medicine, and will continue to demonstrate; but our confidence in that law must not blind us to the dawning of the new era of preventive medicine, the establishment of immunity to infection, eradicating infection by mechanical means, employment of light and air, serum therapy, psychic therapy, sanitation, dietetics and surgery, which have demonstrated beyond question that they are of tremendous importance in curing and controlling disease. "He does well, who in the forest wild,

slays the monster and saves the child; but he does better and merits more, who drives the wolf from the poor man's door." So he does well, who in the fight against disease, slays the monster and saves the victim, even though the latter be torn and bleeding, and may be maimed for life; but he does better and merits more, who sees the approaching shadow of the monster, disease, and annihilates him and his kind.

I am informed, since coming to this meeting, that Dr. Wright, of London, the discoverer of the Iposonic Index, has expressed himself that bacterial vaccination or the establishment of immunity to disease is Homeopathy, pure and simple. Are we to allow the old school men to point out to us the scope of Homeopathy, while we sit still and do nothing but search for the indicated remedy? We must be making research ourselves, and to do that we must be in that receptive attitude of mind which accepts on trial all there is discovered in medicine; and until we do that, neither Homeopathy nor the individual practitioner of that school will progress.

Now that I have made some strong statements, I am going to qualify them just a little. You may have heard of the preacher who had preached a red hot sermon on repentance and hell, and then realized that he had doomed his entire congregation to that abode of perpetual summer. He said, "My brethren, you must repent, as it were; and be converted to some extent, or you will be damned, in a measure."

The time will probably never come in which we shall treat disease exclusively without drugs, and in the giving of those drugs we must have a guiding principle; and that law will be Hahnemann's law.

I am a Homeopath, and I am a firm believer in the law of similars, and if I have made any success in my chosen field—surgery, I am indebted in a measure to that law for such success; but we must not claim so much for it that we lose sight of the arrow head.

But what will become of our colleges? They will continue in the future, as in the past, to prepare men to practice scientific medicine in the broadest and most liberal manner. They will teach homeopathic therapeutics, not as a "cure-all," but as a means of curing those diseases which can only be reached by internal medicine.

I have no patience with that back number Homeopath, who is constantly berating our homeopathic colleges because they do not teach more Homeopathy. Our best homeopathic colleges are teaching the young men just what they ought to know— the best, safest, quickest and most effectual method of combating disease; and if there is less Homeopathy taught (as there certainly is), it is because other methods have been discovered for treating certain diseases which accomplish the cure more rapidly and effectually. Our teachers in these colleges are alert to discover what is demanded of the physician of to-day, and they are putting the emphasis where it belongs. Because some of our teachers are not giving the students four hours per day of Homeopathy, and one-half hour

of pathology and diagnosis, the moss-backs howl that they are mongrel colleges and have no right to be called homeopathic.

Again he howls because our physicians are not spending enough time in studying their materia medica. He says we have become lazy. I know full well that our homeopathic materia medica can only be used with success by diligent study; but the emphasis may be put in the wrong place, and this faultfinding Homeopath may be just the man who would spend hours in searching for a similimum which would cover a pelvic pain for one of his women patients, and six months later be aroused from reverie to find his patient had developed an inoperable cancer. Even then, he does not realize that her death's blood is upon his hands.

Now, look at the other side: A student who has only yesterday graduated from one of these so-called mongrel colleges, is called to a similar case. His first thought is not of his materia medica or the similimum. He only remembers that his teacher taught him not to prescribe for a pain until he had exhausted every reasonable resource to find what caused the pain; and so this twenty-four-hours-old physician discovers the incipient cancer, and saves the life of the patient. Which is more scientific, and which man has done the greatest honor to Homeopathy?

We are, I fear, using the old Hebrew's trick: making the golden serpent, which cured one generation, the God of the next. Are we not making a God of our Homeopathy and worshipping it? If so, Homeopathy is doomed, for Gods never progress; they are supposed to be perfect.

According as our colleges teach all there is to medicine, plus Homeopathy, just accordingly will they stand or fall in the race with the colleges of the old school. We must teach everything the old school does, and teach it just a little better, else we fail. As Homeopathy is to become an integral part of scientific medicine, so our colleges will take their places as institutions of medical learning; but they must have something more to recommend them than the mere fact that they teach Homeopathy.

Just one word about the general practitioner, and I am through: You may think, because I have assigned internal medicine to comparative oblivion, I have also assigned the general practitioner to the same shade; but far from it. There never was a time in the history of medicine when the family physician could, and of necessity must occupy the place which he will in the coming years. As medical inspection of the public schools has disclosed the startling fact that but a small per cent. of children are physically perfect, so the family physician of the future must assume the responsibility of discovering and anticipating these physical ills amongst the children of his patients. He must be a sanitarian, to prevent illness from improper housing and environment. He must be an expert diagnostician, to recognize the earliest signs of organic disease, and by prompt action avert untimely death. He must be a Sherlock

Holmes to trace the source of infection and thereby cut short a trail of sickness and death. He must be a high priest, teaching the youth of the land that the wages of sin is physical death, not to the offender alone, but to that innumerable host of hapless victims left in his wake. He must ever stand between his patient and disease, calling upon the officers of the law or the medical specialist, as he may require them to help him do battle with the foe; for the strong right arm of the law and the specialist are his to command, because he is General.

My friends, I have a toast to propose. You can drink it or not, as best suits you:

The Future of Homeopathy—an integral part of the science of medicine, which in the fusing has made that science clearer, more powerful, more health-giving; and the personnel of its followers lost only as they swell the mighty cohorts in their charge against disease.

CONSTITUTION AND BY-LAWS.

CONSTITUTION.

ARTICLE I.—NAME.

§ 1. In pursuance of Chap. 268, Laws of 1862, by which it was incorporated, this association shall be known as the Homœopathic Medical Society of the State of New York.

§ 2. Its objects shall be the advancement of homœopathic therapeutics and of all other departments of medicine and surgery.

ARTICLE II.—MEMBERS.*

The Society shall be composed of regular, senior and honorary members as may be chosen in conformity with the By-Laws.

ARTICLE III.—SECTION 1.

"The officers of this Society shall be a President, three Vice-Presidents, a Secretary, Treasurer, Necrologist and twelve Censors, four of whom shall be elected annually, one from each district; such four shall serve for three years.

Upon the first election immediately following the adoption of this by-law, twelve Censors shall be elected, four of whom shall serve for three years, four for two years and four for one year. Each district must have a representative in each group elected.

All officers shall be elected in accordance with Article I., Section 6, of the By-Laws.

ARTICLE III.—SECTION 2.

Their term of office shall commence at the close of the meeting at which they were elected, and shall continue for one year, with the exception of the Censors, who shall serve as mentioned in Section 1.

ARTICLE IV.—SEAL.

The subjoined, either printed or embossed, shall be the official seal of the Society.

*This Society "may elect such a number of permanent, delegate or other members as may be provided by the constitution or by-laws," and is "empowered to regulate and control its own membership." Laws of 1882, Chap. 209.

ARTICLE V.—MEETINGS.*

§ 1. The annual meeting shall be held each year at Albany, commencing on the second Tuesday in February.

§ 2. A semi-annual meeting may be held at such time and place as the Society shall determine.

§ 3. Special meetings may be called by the Executive Board, or by the President, upon the call of ten active members.

ARTICLE VI.—QUORUM.

Ten active members shall constitute a quorum.

ARTICLE VII.—AMENDMENTS.

Any article of this constitution may be amended at an annual meeting by a two-thirds vote of the active members present, provided that a written notice shall have been given at the preceding annual meeting.

BY-LAWS.

ARTICLE I.—DUTIES AND ELECTION OF OFFICERS.

§ 1. The duties and responsibilities of the president, vice-presidents, secretary, treasurer and necrologist shall be such as are usually incident to these offices.

§ 2. The President shall deliver an address at the annual or semi-annual meeting, appoint standing committees, bureaus and delegates, make appointments to fill vacancies and be ex-officio member of all committees.

§ 3. The Secretary, in addition to his other duties, shall annually edit the Transactions of the Society and the State Directory of Homœopathic Physicians, consulting with the Executive Board when he or they deem it necessary.

He shall be paid a salary of three hundred dollars per annum.

§ 4. The Treasurer shall keep the funds of the Society in a bank, or trust company approved by the Executive Board, and the account shall stand in the name of the Society.

Each year he shall furnish a copy of the current issue of the Transactions to each regular member in good standing and to all senior and honorary members.

At each annual meeting he shall report the names of such members as are dropped for non-payment of dues, and shall furnish the tellers with a list of the active members entitled to vote.

He shall turn over to his successor all property of the Society in his charge.

In lieu of salary he shall be reimbursed for his traveling expenses incurred in attending the meetings of the Society, and such other expenses as may be approved by the Executive Board.

§ 5. It shall be the duty of the Censors to consider all applications for regular membership, reporting to the Society at the same or next meeting such as they judge to be properly qualified for election.

Three shall constitute a quorum.

§ 6. At the semi-annual meeting in each year, nominations shall be made in open meeting for all elective offices to be filled at the next annual meeting. A time shall be specified in the program for such nominations and notice thereof shall be incorporated in the announcement of the meeting.

Any ten members may certify to the Secretary on or before January first of any year, a nominee for any or all offices to be filled at the next annual meeting.

---

*This Society may select the time and place for holding its annual and other Meetings. Laws of 1875, Chap. 449.

The Executive Committee shall nominate at least one candidate for each and any office which may be left unfilled by other nominations.

On or before January twentieth the Secretary shall send to each member a ballot containing a list of such nominees as have signified to him their acceptance of such nomination. Each member shall indicate his choice by a cross prefixed to one nominee for each office.

The ballot shall be unsigned and sealed in an envelope marked "ballot," furnished by the Secretary, which shall be enclosed in an envelope endorsed by the member's name and address. A ballot shall be counted only in so far as it is marked in accordance with the above.

The polls shall close on February fifth. Only the ballots of members certified by the Treasurer as being good standing shall be opened and counted, in the presence of three tellers, on or before the first day of the annual meeting. After canvassing the ballots, the tellers shall certify the results to the President on or before 11 A. M. on the second day of the annual meeting.

In case no nominee for any office receives a plurality of the ballots cast previous to the annual meeting, open nominations for such office or offices shall be made at 11 A. M. on the second day of the annual meeting, and balloting continued until a nominee receives a majority vote.

Three tellers shall be appointed by the President before February fifth of each year.

ARTICLE II.—MEMBERSHIP.

§ 1. Any physician desiring Regular Membership must be of good moral and professional standing, and legally licensed to practice medicine under the laws of this State.

The candidate must sign the following form, properly filled out and indorsed, which form must be accompanied by a fee of five dollars, which includes the dues for the current year and membership fee:

"I request membership in the Homœopathic Medical Society of the State of New York. I agree, if elected, to pay my dues promptly and regularly to the Society. I promise to return promptly to the Secretary my certificate of membership if and when I resign or am dropped from the Society. I hereby acknowledge that I believe *Similia Similibus Curentur*. I reside at No. ..... in ..... County of..... and am a graduate of.....in the year.....My license to practice is..... dated .....(Signed) (date). The undersigned regular members indorse the above applicant as worthy of regular membership in this Society. (Signed).....and.....

After having been favorably reported on by the Censors and accepted by a majority vote of the active members present at a regular meeting, the candidate shall become a regular member entitled to the rights and privileges of membership, including a certificate of membership.

The first, second and third paragraphs of this section shall be printed upon the application blanks.

§ 2. Any regular member may be elected a Senior Member at an annual meeting, provided that at the time of such election he or she is in good standing and shall have paid dues for twenty-five years.

Senior members shall be exempt from dues and assessments, and shall be entitled to all rights and privileges of membership.

§ 3. Any physician or surgeon not a resident of this State, who has manifested superior attainments in medicine or one of its collateral sciences, may be elected an Honorary Member at an annual meeting, provided that the nomination, accompanied by reasons for conferring the honor, shall have been made at a previous regular meeting. Not more than three honorary members shall be elected in any one year.

Honorary members may participate in the proceedings of this Society (except that they shall not vote nor be eligible to office) and are requested to contribute papers. They shall be entitled to receive the volumes of Transactions.

ARTICLE III.—DUES.

§ 1. The annual dues shall be three dollars from each regular member.

§ 2. Each regular member shall pay a membership fee of five dollars, which shall include the dues for the current year, at the time of his or her election.

§ 3. No member in arrears shall be entitled to the privileges of membership.

Members three years in arrears shall be dropped from the roll.

ARTICLE IV.—COMMITTEES AND BUREAUS.

§ 1. The Executive Board, consisting of the president, vice-presidents, secretary and treasurer, shall act as the executive committee of the Society, attending to matters not otherwise provided for, or that may be referred to it.

When necessary it may call a special meeting of the Society, specifying time, place and object.

It shall serve as an advisory committee of publication with discretionary power as to the appearance in the Transactions of any given report or paper.

§ 2. The President-elect shall annually appoint the chairman, of the Committee on State Medical Examiners and a chairman, with at least two members, of the Committee on Legislation and of each of the following bureaus: Materia Medica, Clinical Medicine and Pathology, Surgery, Obstetrics, Gynæcology, Pædiatrics, Neurology, Ophthalmology and Otology, Laryngology and Rhinology, and Public Health.

ARTICLE V.—PAPERS.

§ 1. All papers, communications and reports read before or presented to this Society become thereby its property, and must be at once deposited with the Secretary. They may afterward, by means of copies, be published in medical journals if due credit be given to this Society.

§ 2. No paper nor report shall be received for publication that has previously been either published or presented to another society, or that is in an unfinished condition.

§ 3. Only fifteen minutes shall be allowed for the reading of a paper, ten minutes each for its opening and closing discussion, and five minutes each for other remarks discussing it. This rule may be suspended only by the unanimous consent of those present.

ARTICLE VI.—STATE MEDICAL EXAMINERS.*†

§ 1. This Society shall at each annual meeting, by a majority vote, nominate to the Regents of the University for appointment as State Medical Examiners at least twice as many persons as there are appointments to be made.

§ 2. Each nominee must be a member of this Society in good standing, must have been graduated in course from a reputable medical college, and must have been practicing medicine or surgery under the laws of this State for at least five years immediately prior to the first of July following said nomination.

§ 3. The Secretary shall send to each regular member of this Society, a week before the annual meeting, the nominations by the Committee on State Medical Examiners of at least three times as many nominees as there are appointments to be made.

Each active member present may, between twelve and twelve-thirty P. M. of the second day of the annual meeting, deposit with two special tellers appointed by the president, a ballot for at least twice as many nominees as there are appointments to be made. Such names as receive a majority of the votes cast shall be presented to the Regents.

*Laws of New York, 1890, Chap. 507.

†NOTE:—An amendment was offered at the Semi-Annual Meeting, to be acted upon at the Annual Meeting, to strike out Article VI and words in Articles IV and VII, relating to State Medical Examiners, owing to new State law regarding the same.

In case a sufficient number of names (twice the number of appointments to be made) do not receive a majority vote, the quota shall be filled by a ballot upon names submitted in open nomination.

§ 4. If charges of unprofessional or dishonorable conduct or continued neglect of duty are made against any State Medical Examiner representing this Society, the Society, after considering the matter in Committee of the Whole, may, by a majority vote, at any regular or special meeting submit the evidence in the case to the Regents and may request the removal of said Examiner.

§ 5. The Committee on State Medical Examiners shall consist of five members, to be elected by ballot at the annual meeting. The chairman shall be appointed from among their number by the President-elect within three weeks. Their term of office shall commence at the close of the meeting at which they are elected and shall continue one year to the close of the next annual meeting, and until their successors are elected.

ARTICLE VII.—ORDER OF BUSINESS.

At the meetings of this Society the following shall be the Order of Business, unless otherwise prescribed by the Executive Board or changed by the Society.

Prayer.
Communication from the President.
Appointments:
- Committee on Attendance;
- Committee on President's Address;
- Auditing Committee;
- Tellers.

Minutes of the last meeting.
Report of the Board of Censors.
Elections:
- of Members—Regular, Senior, Honorary;
- of Officers (at time specified):
- of Nominees as State Medical Examiners (at time specified);
- of Committee on State Medical Examiners.

Reports:
- of Officers;
- of Committees;
- of Bureaus.

Miscellaneous business.

ARTICLE VIII.—GOVERNMENT.

This Society shall be governed by the Code of Ethics adopted by the American Institute of Homœopathy, and by parliamentary usage as set forth in Roberts' Rules of Order for Deliberative Assemblies.

ARTICLE IX.—AMENDMENT.

These By-Laws may be amended by a two-thirds vote of the active members present at an annual meeting, provided that written notice shall have been given at a previous regular meeting.

STANDING RESOLUTIONS.

DELINQUENT MEMBERS.

Whereas, It has been proposed that members dropped for non-payment of dues, asking to be reinstated should have their back dues remitted, and

Whereas, It would seem that such action would be prejudicial to the best interests of the Society by encouraging delinquency; therefore

Resolved, That the power of re-instatement in such cases be vested in the Executive Board, with the understanding that such leniency shall be exercised only in exceptional cases where unfortunate circumstances seem to render it necessary.

Adopted, Feb. 9, 1892.

PAPERS BY TITLE.

Resolved, That when the writer of a paper is not in attendance upon the meeting at which it is presented, the said paper shall be read by title. The only exception to be made to this rule shall be when the work of the Society is ahead of the schedule in point of time.

Adopted, Feb. 12, 1895.

POSTAL NOTICE.

Not more than three nor less than two weeks previous to every regular meeting the Secretary shall send to each member a (postal card) notice of its date and place.

Adopted, Feb. 8, 1898

ANNUAL REPORT OF TREASURER.

The Treasurer shall present to the Society, in his annual report, a detailed statement of the expenditures of the Society, not merely giving the bulk expenditures alone.

Adopted, Feb. 12, 1901.

REINSTATEMENT OF MEMBERS.

Resolved, That any former member of this Society who has resigned therefrom in good standing with the Society, may be reinstated upon his request, by making out and presenting the usual application without paying the initiation fee, when such application has been approved by the Censors.

Adopted, Sept. 25, 1901

COMMITTEE ON EXHIBITS.

The President shall appoint annually a Committee of from one to three members, to arrange the details connected with trade exhibits and to be known as the Committee on Exhibits.

Adopted, Feb. 14. 1905.

The Chairman of the Committee on Exhibits shall have his traveling and other necessary expenses paid by the Society.

Adopted Feb. 13. 1906.

COMMITTEE ON INCREASING MEMBERSHIP.

Resolved, That the Committee on Increasing Membership shall consist of fifteen members.

Adopted Feb. 13. 1906.

SPECIAL ACCOUNTS.

Every account of an officer or committee exceeding twenty dollars in amount shall be passed upon by an auditing committee before payment.

Adopted Feb. 13, 1907.

GUESTS OF THE SOCIETY.

The Society will not invite more than one guest to contribute to the proceedings of any given meeting.

Adopted Feb. 13, 1907.

TO AID THE TREASURER.

The Treasurer is authorized to employ a collector at his discretion.

Adopted Feb. 13, 1907.

PAPERS ANNOUNCED BUT ONCE.

No paper shall be announced on the program of more than one meeting, except by a vote of the Society.

Adopted Feb. 13, 1907.

BOARD OF STATE MEDICAL EXAMINERS.

That the Homeopathic members of the State Board of Medical Examiners be requested to render an annual report to this Society.

Adopted Sept. 25, 1907.

OFFICERS, 1850–1907

Year.	Presidents.	1st Vice-President.	2nd Vice-President.	3rd Vice-President.	Secretary.	Treasurer.	Cor. Secretary.
1850.	*Isaac M. Ward, Albany.	*D Chase.	*R. S. Bryan	*A. C. Ball.	*Henry D. Paine.		
1851.	*F Vanderbergh, New York.	*L. Clary.	*F. Humphreys.	*Geo. W. Lewis.	"		
1852.	*Lyman Clary, Syracuse.	*Alonzo S Ball.	*E L. Coburn.	*D. Chase.	"		
1853.	*Alonzo S. Ball, New York.	*N. H. Warner.	*S S. Guy.	*L. B. Wells.	"		
1854.	*Amherst Childs, Waterloo.	*Henry Adams.	*Josiah Bowers.	*E. T. Richardson.	"		
1855.	*Samuel S. Guy, Brooklyn.	*M. M. Matthews.	*R S. Bryan.	*David Springsteed.	"		
1856.	*M. M. Matthews, Rochester.	*J. M. Quinn.	*Henry Adams.	*L. B. Wells.	"		
1857.	*R. S. Bryan, Troy	*A. P. Cook.	*L. B. Wells.	*J. C. Peters.	"	*J. W. Cox.	
1861.	*Ethan A. Potter, Oswego.	*Simeon A. Cook.	*A. R. Wright.	*Cornelius Ormes.	*Horace M. Paine.	"	
1862.	*Jacob Beakley, New York.	*A. R Wright.	*E A Munger.	W. S. Searle.	"	*L. B. Wells.	
1863.	*Henry D. Paine, New York.	*William Wright.	*C. W. Boyce.	Asa S. Couch.	"	"	
1864.	*Erastus A. Munger, Waterville.	*S S. Guy.	*A. R. Morgan.	Asa S. Couch.	"	"	
1865.	*Abijah P. Cook, Hudson.	*Benj. F. Cornell.	*Benj F. Bowers.	*L. M. Kenyon.	"	"	H. B. Fellows.
1866.	*Horatio Robinson, Auburn.	*Lucien B. Wells.	*Wm. B. Stebbins.	*Edgar B. Cole.	"	*J. S. Delavan.	"
1867.	*B. F. Cornell, Moreau Station.	*S. B. Barlow.	William H Watson.	*L. M. Pratt.	H. B. Fellows.	*J. W. Cox.	*E D. Jones.
1868.	William H. Watson, Utica.	*T. F. Allen.	*T. L Brown.	*D. F. Bishop.	*H. M. Paine.	W. S. Searle.	"
1869.	*William Wright, Brooklyn.	E. B. Holmes.	*Henry Minton.	*E. P. K. Smith.	"	"	"
1870.	*Lucien B. Wells, Utica.	*Edwin H. Hurd.	*Ezra P. K. Smith.	T. Franklin Smith.	"	"	"
1871.	*John F Gray, New York.	T. Franklin Smith.	J. C Raymond.	*A. W. Holden.	"	*J. F. McKown.	"
1872.	*H. A. Houghton, Keesville.	*Charles Sumner.	H S Hutchison.	*G. L. Gifford.	"	Nelson Hunting.	*L. M. Pratt.
1873.	*E. Darwin Jones, Albany.	*D. F. Bishop.	*J. Ralsey White.	R. E Miller.	*Frank L. Vincent.	"	"
1874.	*L. M. Kenyon, Buffalo	*A. E Sumner.	*S. C. Knickerbocker.	*Henry Sales.	"	*F. L. Vincent.	"
1875.	*A. W. Holden, Glens Falls.	*E. M. Kellogg.	*H. V. Miller.	R. S. Bishop.	"	*E. D. Jones.	"
1876.	*T. F. Allen, New York.	*A. R. Wright.	*William Gulick.	*Henry R. Stiles.	Alfred K. Hills.	*F. L. Vincent.	"
1877.	*Egbert Guernsey, New York.	*William Gulick.	*Henry R. Stiles.	H. D. Brown.	"	E. S. Coburn.	H. L. Waldo.
1878.	*William Gulick, Watkins.	*A. R Wright	*W. M L Fiske.	*A P. Throop.	"	"	"
1879.	Asa S. Couch, Fredonia.	Alfred K Hills.	E Hasbrouck.	J. J. Mitchell.	H. L. Waldo.	"	*A. P. Hollett.
1880.	*A. R. Wright, Buffalo.	*E Hasbrouck.	*N. Osborne.	R A. Adams.	"	"	"
1881.	*Selden H. Talcott, Middletown.	J. J. Mitchell.	A. J. Frantz.	*G. W. Peer.	*A. P. Hollett.	"	*C. E. Jones.
1882.	J. J. Mitchell, Newburgh.	*E. Hasbrouck.	W B Kenyon.	W. M. Butler.	"	"	NECROLOGIST.
1883.	*Everitt Hasbrouck, Brooklyn.	W B. Kenyon.	A. P. Williamson.	L. A. Clark.	"	"	*A. W. Holden.
1884.	Edward S. Coburn, Troy.	*Henry C. Houghton.	*H. M. Dayfoot.	*A. P. Hollett.	John L Moffat.	H. L. Waldo.	"
1885.	Marshall O. Terry, Utica.	*A. P Hollett.	N. B. Covert.	George M. Dillow.	"	E. S. Coburn.	"
1886.	*Henry C. Houghton, New York.	F. Park Lewis.	*T. L. Brown.	E. W. Bryan.	*H. M. Dayfoot.	"	"
1887.	*Horace M. Paine, Albany.	*Wm. Tod Helmuth.	J. M. Lee.	Geo. E. Gorham.	"	"	"
1888.	*Wm. Tod Helmuth, New York.	Thos. D Spencer.	*L. A. Bull.	John L. Moffat.	"	Arthur B. Norton.	"
1889.	*Herbert M. Dayfoot, Rochester.	*F. F. Laird.	J. T Greenleaf.	Sidney F. Wilcox.	John L. Moffat.	"	H. L. Waldo.
1890.	George M. Dillow, New York.	N. B. Covert.	J. M. Lee.	W. B. Gifford.	"	"	"
1891.	F. Park Lewis, Buffalo.	A. B. Norton.	L. L. Brainard.	J. W. Sheldon.	"	Charles Deady.	H. D. Schenck.
1892.	*Wm. M. L Fiske, Brooklyn.	*L. A. Bull.	E. J. Bissell.	J. W. Candee.	"	"	"
1893.	J. M. Lee, Rochester.	J. W. Candee.	W. S. Garnsey.	Mary A. Brinkman.	"	"	*E. Hasbrouck.
1894.	James Montfort Schley, New York.	E. J. Bissell.	W. B. Gifford.	W. B. Winchell.	"	"	"
1895.	*Charles E. Jones, Albany.	W. B. Gifford.	D. J. Roberts.	W. L. Hartman.	"	"	"
1896.	Edwin H. Wolcott, Rochester.	G. G. Shelton.	I. Townsend.	*A. R. Wright.	"	"	W. S. Garnsey.

OFFICERS—CONTINUED.

Year.	Presidents.	1st Vice-President.	2nd Vice-President.	3rd Vice-President.	Secretary.	Treasurer.	Necrologist.
1897.	Eugene H. Porter, New York.	John W. LeSeur.	J. W. Dowling.	E. G. Cox.	John L. Moffatt.	Charles Deady.	W. S. Garnsey.
1898.	A. B. Norton, New York.	D. G. Wilcox.	F. W. Adriance.	H. D. Schenck.	"	"	"
1899.	J. W. Sheldon, Syracuse.	F. W. Adriance.	G. E. Gorham.	N. M. Collins.	"	"	"
1900.	William Morris Butler, Brooklyn.	E. W. Bryan.	L. A. Martin.	Emily F. Swett.	DeWitt G. Wilcox.	"	"
1901.	John T. Greenleaf, Owego.	C. T. Haines.	E. G. Cox.	W. H Bishop.	"	W. B. Gifford.	"
1902.	John L. Moffat, Brooklyn.	M. C. Ashley.	Bukk G. Carleton.	C. A. Gwynn.	"	Frederick J. Cox.	"
1903.	John W. LeSeur, Batavia.	E. Rodney Fiske.	Jos. T. Cook.	C. A. Ward.	"	C. T. Haines.	H. W. Paige.
1904.	Bukk G. Carleton, New York.	Martin Besemer.	Ermina C. Eddy.	T. D. Buchanan.	"	"	"
1905.	DeWitt G. Wilcox, Buffalo.	Wm. T. Helmuth.	B W. Sherwood.	Geo. R. Critchlow.	H. W. Paige.	"	John Hutchinson.
1906.	Newton M. Collins, Rochester.	T. Drysdale Buchanan	Fred'k W. Seward, Jr.	Orando S. Ritch.	"	Fred'k M. Dearborn.	John L. Moffatt.
1907.	Herbert Dana Schenck.	F. W. Adriance.	William A. Keegan.	H. D. Cochrane.	"	Reeve B. Howland.	"

*Deceased.

OFFICIAL LIST OF MEMBERSHIP

IN THE

Homœopathic Medical Society of the State of New York.

HONORARY MEMBERS.

		Elected.
Allen, Henry C.	5142 Washington Av., Chicago, Ill.,	1886
Bartlett, Clarence	1506 Arch St., Philadelphia, Pa.,	1890
Bellows, Howard P.	Boston, Mass.,	1907
Biggar, Hamilton F.	166 Euclid Ave., Cleveland, O.,	1887
Blake, J. Gibbs	England,	1882
Breyfogle, W. L.	708 N. Y. Life Bldg., Chicago, Ill.,	1881
Budlong, John C.	604 Westminster, Providence, R. I.,	1881
Clifton, Arthur C.	9 Park Parade, Northampton, Eng.,	1888
Copeland, Royal S.	Ann Arbor, Mich.,	1907
Drummond, John	Manchester, Eng.,	1870
Edie, John L.	Leavenworth, Kan.,	1870
Emerson, N. W.	685 Boylston St., Boston, Mass.,	1900
Gallinger, J. H.	Concord, N. H.,	1881
Gilchrist, James G.	615 N. Dubuque St., Iowa City, Ia.,	1888
Hayward, John W.	61 Shrewsbury Road, Birkenhead, Cheshire, Eng.,	1882
Heath, Edwin R.	Kansas City, Kan.,	1868
Henderson, William	Edinburgh, Scotland,	1869
Hirschel, B.	Dresden, Saxony, Germany,	1871
Jones, Samuel A.	Ann Arbor, Mich.,	1882
Linnell, E. H.	61 Broadway, Norwich, Conn.,	1891
Madden, H. R.	London, Eng.,	1870
Mandeville, F. B.	Newark, N. J.,	1873
McGeorge, Wallace	521 Broadway, Camden, N. J.,	1884
Packard, Horace	470 Commonwealth Ave., Boston, Mass.,	1900
Paine, N. Emmons	West Newton, Mass.,	1904
Pope, Alfred C.	Monkton, Ramsgate, Eng.,	1871
Roth, Mathias	London, Eng.,	1871
Runnels, O. S.	203 N. Meridian St., Indianapolis, Ind.,	1882
Sanders, John C.	608 Prospect St., Cleveland, O.,	1865
Shears, G. F.	3130 Indiana Ave., Chicago, Ill.,	1900
Skinner, Thomas	6 York Pl., London, W., Eng.,	1878
Van Lennep, W. B.	1421 Spruce St., Philadelphia, Pa.,	1900
Wanstall, Alfred B.	921 Cathedral St., Baltimore, Md.,	1904
Wilson, David	London, Eng.,	1865
Wood, James C.	122 Euclid Ave., Cleveland, O.,	1891
Worcester, Samuel	Stamford, Conn.,	1873

REGULAR MEMBERS.

(*Senior Members in Small Capitals.*)

Adams, Myron H.	56 Park Ave., Rochester,	1892
Adams, R. A.	418 Powers Building, Rochester,	1899
Adriance, F. W.	306 Lake, Elmira,	1883
Albertson, C. S.	9 West Bridge, Oswego,	1900
Allen, Emma T. P.	461 Washington Ave., N. Y., Bkn.,	1899
Allen, J. Wilford	117 W. 12th, New York, Mhn.,	1905
Allen, Herbert C.	304 Clermont Ave., New York, Bkn.,	1899
Allen, Paul	3 E. 48th, New York, Mhn.,	1892
Alliaume, Chas. E.	18 Clarendon Bldg., Utica,	1902
Ambler, J. Edgar	102 E. 26th, New York, Mhn.,	1893
Andrews, B. P.	103 Main, Dansville,	1893
Angel, Milton H.	Salt Point,	1902
Arthur, Daniel H.	Gowanda State Homœopathic Hospital, Gowanda,	1891
Ashley, M. C.	Middletown,	1894
Avery, E. W.	16 Hancock, New York, Bkn.,	1889
Badgley, Coburn	Fayetteville,	1904
Bagg, Clinton L.	26 W. 46th, New York, Mhn.,	1904
Bailey, Chas. Lee	273 Clinton Ave., Albany,	1905
Baker, Allen E.	55 Franklin, Auburn,	1905
Baker, Harold H.	301 Lake Ave., Rochester,	1907
Baker, John W.	Batavia,	1906
Baker, Jennie V. H.	512 Bedford Ave., New York, Bkn.,	1889
Baldwin, G. E.	Jay,	1898
Baldwin, Jared G.	8 E. 41st, New York, Mhn.,	1894
Ball, Halsey J.	Cortland,	1891
Ballou, Harry B.	State Hosp., Middletown,	1906
Barnard, J. S.	2112 N. Charles, Baltimore, Md.,	1886
Barnes, Charles F.	Weedsport,	1893
Barrus, Clara	Middletown,	1894
Bartlett, G. Waldron	167 Bay 28th, Bensonhurst,	1904
BAYLIES, B. L'B (1906)	418 Putnam Ave., New York, Bkn.,	1883
Beals, Herbert	188 Franklin, Buffalo,	1889
Beattie, Joseph H.	Dobb's Ferry,	1905
Beck, Edwin G. H.	694 Clinton Ave., Rochester,	1905
Beckwith, Sidney A.	275 Warburton Ave., Yonkers,	1907
Bedford, Edwin R.	437 Putnam Ave., Brooklyn,	1905
Beers, M. I.	100 Highland, Middletown	1904
Bell, Willard N.	6 Greene, Ogdensburgh,	1890
Benson, Reuel A.	8 W. 49th, New York, Mhn.,	1905
Benson, R. F., Jr.	2 St. Paul Pl., Troy,	1886
Berghaus, Alex.	160 W. 92d, New York, Mhn.,	1888
Besemer, Arthur	Despatch,	1904
Besemer, H. B.	232 S. Albany, Ithaca,	1904
Besemer, Martin	224 S. Albany, Ithaca,	1897
Beyea, J. L.	28 E. 47th, New York, Mhn.,	1894
Bierbauer, Bruno W.	47 Pierrepont, New York, Bkn.,	1898
Bingham, Harvey V.	State Hosp., Middletown,	1906
Birch, Chas. E.	White Plains,	1894
Birdsall, W. G.	Clintondale,	1904
Birdsall, S. T.	80 Ridge, Glens Falls,	1883
Birdsall, T. P.	Patterson,	1892
Bishop, F. M.	Endicott,	1891
Bishop, W. H.	667 Madison Ave., New York, Mhn.,	1893
Bissell, E. J.	75 S. Fitzhugh, Rochester,	1889
Blackley, C. A.	70 Main, Lockport,	1901
Blackman, W. W.	519 Clinton Ave., New York, Bkn.,	1890
Bond, G. W.	Keesville,	1906

Borden, G. T.	Caledonia,	1887
Bornmann, A.	229 Madison Ave., N. Y., Bkn.,	1904
Boyle, Chas. C.	49 W. 37th, New York, Mhn.,	1888
Boynton, F. H.	36 W. 50th, New York, Mhn.,	1888
Boynton, L. R.	Mt. Vernon,	1905
Brewster, Geo. F.	Middletown,	1902
Brennan, Francis E.	1445 Amity St., Flushing,	1907
Brown, Chester R.	Metropolitan Hosp., New York,	1907
Brown, E. V.	N. Tarrytown,	1886
Brown, E. Wilton	Mount Kisco,	1903
Brown, M. Belle	30 W. 51st, New York, Mhn.,	1892
BRYAN, E. W. (1900)	22 W. Erie Ave., Corning,	1880
Bryant, Wm. C.	66 Greene Ave., New York, Bkn.,	1899
Buchanan, T. Drysdale	210 W. 57th, New York, Mhn.,	1892
Buchholz, Louise Z.	73 E. 8th, New York, Mhn.,	1892
Buell, Jesse W.	67 Chestnut, Rochester,	1889
Burnham, Clark	182 Clinton, New York, Bkn.,	1889
Butler, Wm. M.	507 Clinton Ave., New York, Bkn.,	1881
Button, Lucius L.	265 Alexander, Rochester,	1904
Calisch, Alex. C.	Hotel Redstone, Oswego,	1896
Campbell, Wm. M.	176 Remsen St., Cohoes,	1907
Candee, J. W.	501 Fayette Park, Syracuse,	1885
Capron, C. G.	1 Hopper, Utica,	1900
Carleton, Bukk G.	75 W. 50th. New York, Mhn.,	1892
Carleton, Sprague	75 W. 50th, New York. Mhn.,	1907
Carpenter, A. D.	69 E. Parade Ave., Buffalo,	1902
CARROLL, S. H. (1900)	234 State, Albany,	1874
Carter, Grace B.	10 Cumberland St., Rochester,	1906
Chadwick, John G.	274 Richmond Ave., Buffalo,	1899
Chamberlin, W. T.	838 Park Pl., New York, Bkn.,	1899
Chandler, D. Henry	Cornwall-on-Hudson,	1894
Chapin, Edward	21 Schermerhorn, New York, Bkn.,	1883
Charles, Emily C.	51 W. 127th, New York, Mhn.,	1898
Chase, C. E.	137 Park Ave., Utica,	1882
Chase, J. Oscoe	214 E. 53d, New York, Mhn.,	1888
Church, H. A.	601 Warren, Syracuse,	1898
Clark, Bert. B.	6 W. 129th, New York, Mhn.,	1904
Clark, Byron G.	25 W. 74th, New York, Mhn.,	1891
Clark, Mary E.	Chatham,	1905
CLARK, L. A. (1904)	Cambridge,	1879
Clapp, Charles R.	427 Hayward Ave., Rochester,	1901
Close, Stuart	248 Hancock St., New York, Bkn.,	1907
COBURN, EDWARD S. (1903)	91 Fourth, Troy,	1874
Cochrane, H. D.	59 Eagle, Albany,	1900
Cole, John D.	Alexandria Bay,	1905
Cole, Hills	1748 Broadway, New York, Mhn.,	1905
Cole, Wm. W.	Silver Creek,	1905
Coleman, Daniel E. S.	101 W. 78th, New York, Mhn.,	1904
Cole, Harlan P.	1748 B'way, New York, Mhn.,	1905
Coles, Howard L.	Tarrytown,	1904
Collins, N. M.	43 East Ave., Rochester,	1886
Conklin, R. C.	29 Ellicott Ave., Batavia,	1902
Conley, Lawrence P.	Clifton Springs,	1904
COOK, C. P. (1904)	Hudson,	1872
Cook, J. T.	636 Delaware Ave., Buffalo,	1883
Cooper, C. S.	Skaneateles,	1896
Cort, Lottie Ambler	89 Division Ave., New York, Bkn.,	1903
Corwin, Elizabeth	104 Main, Binghamton,	1892
COUCH, ASA S. (1894)	Fredonia,	1864
COVERT, N. B. (1904)	Geneva,	1878
Covert, Rynear B.	Seneca Falls,	1892
Cox, Edward G.	261 State, Albany,	1894
Cox, F. J.	109 State, Albany,	1894

Cox, G. A.	80 S. Swan, Albany,	1878
Critchlow, Geo. Reed	505 Norwood, Buffalo,	1901
Crowell, Lewis C.	314 S. Crouse Ave., Syracuse,	1905
Crum, Harry Herbert	212 Hazen, Ithaca,	1901
Crump, Walter Gray	837 Madison Ave., N. Y., Mhn.,	1902
Cummings, Frank M.	Warwick,	1907
Danforth, L. L.	49 W. 52d, New York, Mhn.,	1888
Davis, Arthur E.	Pittsford	1906
Davis, J. E. L.	743 Madison Ave., New York, Mhn.,	1891
Deady, Charles	151 W. 73rd, New York, Mhn.,	1888
Deady, H. P.	Liberty,	1899
Dean, L. W.	41 Gardner Building, Utica,	1899
Dearborn, Fred'k M.	55th & 7th Av., New York, Mhn.	1903
Decker, W. M.	242 Ashland, Buffalo,	1883
Delabarre, W. E.	212 W. 49th, New York, Mhn.,	1894
Demarest, J. H.	52 W. 126th, New York, Mhn.,	1892
Denison, R. N.	542 N. Broadway, Saratoga,	1899
Deuel, W. Estus	Canastota,	1891
Dewey, Willis	Ann Arbor, Mich.,	1894
Dieffenbach, Wm. H.	1748 Broadway, New York, Mhn.,	1902
Dillingham, T. M.	8 W. 49th, New York, Mhn.,	1891
Dillow, George M.	223 W. 57th, New York, Mhn.,	1889
Doane, W. H.	75 Clinton Ave., Rochester,	1893
Dominick, G. C.	70 W. 55th New York, Mhn.,	1905
Dowling, J. Ivimey	223 State, Albany,	1900
Dowe, F. LeC.	Bedford Pk., New York, Mhn.,	1892
Dowling, J. W.	56 W. 50th, New York, Mhn.,	1889
Drury, Alfred	122 Broadway, Paterson, N. J.,	1901
DuBois, W. C.	519 S. Salina, Syracuse,	1893
DUTCHER, M. T. (1904)	Owego,	1884
Eddy, Ermina C.	500 William, Elmira,	1883
Eife, A. E.	175 West 10th St., New York, Mhn.,	1888
Eisenbrey, E. H.	Gloversville,	1897
Elliott, Amos H.	480 Monroe, New York, Bkn.,	1890
Erb, Peter	32 Palace Arcade, Buffalo,	1891
Everett, Edward A.	861 College Ave., Elmira,	1902
Fancher, E.	16 Orchard, Middletown,	1885
Farnsworth, Floyd S.	43 Brinkerhoff, Plattsburg,	1904
Faust, Louis	19 Jay, Schenectady,	1885
Faust, Wm. P.	22 Jay, Schenectady,	1898
Fish, Wilber G.	Ludlowville,	1904
Fiske, E. Rodney	1140 Dean, New York, Bkn.,	1896
Fobes, Joseph H.	230 W. 59th, New York, Mhn.,	1904
Foote, Mary E. Bond	122 Lexington Ave., N. Y., Mhn.,	1892
Foster, E. Agate	Patchogue,	1891
Foster, W. E.	Babylon, L. I.,	1892
Fowler, W. P.	63 Clinton Ave., S., Rochester,	1876
Fralick, W. G.	991 Madison Ave., N. Y., Mhn.,	1892
Franklin, E. D.	368 Convent Ave., N. Y., Mhn.,	1898
Frazier, L. A.	124 Division, Amsterdam,	1892
Freeman, Wm. Hazen	263 Arlington, Brooklyn,	1902
Fryer, Olin G.	945 State, Schenectady,	1907
Gamble, Ellsworth	481 Fulton, Waverly,	1904
Gannett, G. J.	527 So. Salina, Syracuse,	1906
Ganow, Geo. J.	Oxford,	1905
Garnsey, W. S.	93 N. Main, Gloversville,	1888
Garrison, J. B.	115 E. 71st, New York, Mhn.,	1888
Gayde, E. A.	189 Lansing, Utica,	1906
Gennerich, Chas.	71st & B'way, New York, Mhn.,	1902
Getman, V L.	Oneonta,	1906
Gifford, W. B.	Attica,	1886
Gillette, Elizabeth	414 Union, Schenectady,	1903
Gillette, Myra A.	Medina,	1891

Ginnever, Arthur	Glen St., Glen Cove,	1902
Gish, C. L.	Wellsville,	1905
Given, J. B.	463 Ninth, Brooklyn,	1900
Givens, A. J.	Stamford, Conn.,	1891
Goodrich, Frederick W.	Cor. Main & William, Catskill,	1903
Gore, Jennie E.	1145 Park Ave., New York, Mhn.,	1892
Gorham, G. E.	218 State, Albany,	1900
Gorton, D. A.	64 Montague, New York, Bkn.,	1890
Grant, A. R.	321 Genesee, Utica,	1901
Grant, R. C.	823 South Ave., Rochester,	1906
Green, Arba R.	25 Second, Troy,	1902
Green, Crawford R.	25 Second St., Troy,	1907
Greene, C. R. F.	Peekskill,	1894
Greenleaf, J. T.	Owego,	1884
Gregory, G. W.	370 W. Church, Elmira,	1895
Gridley, G. L.	408 University Ave., Syracuse,	1895
Guy, Clement N.	Greene,	1901
Haines, C. T.	42-43 Gardner Bldg., Utica,	1891
Hall, Edwin P.	Skaneateles,	1905
Hall, M. J.	Mamaroneck,	1893
Hall, C. B.	Copenhagen,	1902
Hallett, G. De Wayne	128 W. 85th, New York, Mhn.,	1902
Hallock, J. H.	Saranac Lake,	1880
Hamlin, F. W.	130 W. 48th, New York, Mhn.,	1892
Hardy, Arthur H.	115 First Ave., Mt. Vernon,	1907
Hardy, W. J.	Belmont,	1901
Harris, George F.	Binghamton,	1905
Harrison, Herbert Alexander	196 Genesee, Utica,	1903
Hartley, W. G.	335 W. 34th, New York, Mhn.,	1891
Hartman, W. L.	737-741 University Bldg., Syracuse,	1893
Hasbrouck, Joseph	Dobb's Ferry,	1899
HASBROUCK, SAYER (1904)	117 Broad, Providence, R. I.,	1883
Hassler, J. W.	112 W. 72d, New York, Mhn.,	1904
Hathaway, H. S.	146 W. 92d, New York, Mhn.,	1892
HAVILAND, N. H. (1901)	224 Oneida, Fulton,	1880
Heartwell, W. B.	78 Genesee, Auburn,	1905
Helfrich, C. H.	569 Fifth Ave., New York, Mhn.,	1888
Helmuth, W. T.	26 E. 62d, New York, Mhn.,	1888
Hermance, Alexander C.	595 St. Paul St., Rochester,	1906
Hibbard, D. M.	128 S. Union, Olean,	1893
Hicks, Horace M.	37 Market St., Amsterdam,	1904
Higbie, Annie S.	158 W. 76th, New York, Mhn.,	1904
Hill, Emily L.	207 W. 84th, New York, Mhn.,	1889
Hitchcock, Chas. F.	Sodus,	1905
Hodge, W. H.	8 Gluck Block, Niagara Falls,	1895
Holden, Geo. Parker	175 Warburton Ave., Yonkers,	1904
Hollister, Frederick Kellogg	521 Madison Ave., New York, Mhn.,	1904
Honan, W. F.	70th & Broadway, New York, Mhn.,	1894
Hopkins, Wm. W.	124 Main St., Geneva,	1907
Horton, Claude A.	45 Maple, Glens Falls,	1902
Horton, E. T.	Whitehall,	1897
Hough, W. D.	Niagara Falls,	1891
Howard, Clarence C.	57 W. 51st, New York, Mhn.,	1904
Howe, J. M.	12 W. 46th, New York, Mhn.,	1894
Howland, R. B.	306 Lake, Elmira,	1897
Hoyt, E. F.	39 W. 58th, New York, Mhn.,	1894
Hoyt, Gordon W.	426 Warren, Syracuse,	1898
Hoyt, H. W.	33 Clinton Ave. So., Rochester,	1893
House, Joseph Agate	136 Park Ave., Mt. Vernon,	1907
Hunt, Dwight B.	51 W. 82d, New York, Mhn.,	1887
HUNTING, NELSON (1897)	155 Hamilton, Albany,	1872
Hurd, S. Wright	78 Main, Lockport,	1891
Hutchins, H. S.	Batavia,	1870

Hutchinson, John	75 E. 55th, New York, Mhn.,	1902
Hyde, L. D.	239 Main, Owego,	1894
Iler, George Hills	243 McDonough, New York, Bkn.,	1902
Ingalls, O. DuBois	421 Halsey, New York, Bkn.,	1907
Irish, J. Herbert	422 James St., Syracuse,	1904
Iszard, Walter R.	149 St. Marks Av., N. Y., Bkn.,	1907
Ives, Nathaniel Holmes	145 Second Ave., Mt. Vernon,	1902
Jacobson, Frank A.	269 Grand, Newburgh,	1891
Jeffery, George C.	343 Jefferson Ave., New York, Bkn.,	1887
Jenkins, George H.	139 Main, Binghamton,	1897
Jepson, Mary B.	124 Hamilton, Olean,	1907
Jewett, David Baldwin	68 S. Clinton St., Rochester,	1904
Johns, M. W.	188 Court St., Utca,	1906
Johnson, Howard P.	15 Port Watson, Cortland,	1902
Johnson, Walter W.	17 East Ave., Rochester,	1906
Johnston, C. L.	467 Vanderbilt Ave., N. Y., Bkn.,	1890
Jones, Robt. Mortimer	161 W. 47th, New York, Mhn.,	1904
Kastendieck, J. T. W.	665 St. Marks Av., N. Y., Bkn.,	1890
Kaufman, Louis Rene	257 W. 57th, New York,	1905
Keegan, Wm. A.	40 Clinton Ave., S., Rochester,	1890
Keese, J. Mumford	215 Slocum, Syracuse,	1899
Keith, Horace G.	317 S. Broadway, Yonkers,	1895
Kellogg, Chas. M.	49 Chestnut, Rochester,	1889
Kern, Elmer G.	113 N. Washington St., Herkimer	1907
King, Wm. Harvey	616 Madison Ave., N. Y., Mhn.,	1886
Kingsley, O. D.	White Plains,	1897
Kinne, A. B.	410 Fayette Park, Syracuse,	1882
Kinne, Brayton E.	50 Eagle St., Albany,	1904
Kinne, E. O.	601 Warren, Syracuse,	1899
Knapp, James C.	Geneva,	1892
Knickerbocker, H. DeL.	Springwater,	1906
Krause, William H.	61 E. 86th St., New York, Mhn.,	1905
Laidlaw, Alexander H.	58 W. 53rd, New York, Mhn.,	1897
Laidlaw, Geo. F.	58 W. 53rd, New York, Mhn.,	1894
Land, Joseph F.	40 W. 127th, New York, Mhn.,	1888
Lane, Charles E.	289 Mill, Poughkeepsie,	1893
Lane, Irvin J.	26 Maple, Ossining,	1892
Lannin, Louise	1 West 82d, New York, Mhn.,	1895
Lazarus, Geo. F.	10 Caton Ave., New York, Bkn.,	1900
Leal, Malcolm	171 W. 73d, New York, Mhn.,	1888
Lee, J. M.	179 Lake Ave., Rochester,	1884
LeSeur, John W.	207 E. Main, Batavia,	1890
Leverson, Montague R.	927 Grant Ave., N. Y., Bronx,	1904
Lewis, Fred D.	188 Franklin, Buffalo,	1893
Lewis, F. Park	454 Franklin, Buffalo,	1881
Little, Wm.	Sherburne,	1902
Lloyd, R. I.	450 Ninth, New York, Bkn.,	1900
Lockwood, B. F.	Frewsburg,	1906
Lount, Robert	79 Fulton, Hempstead,	1893
Love, Wm. L.	1188 Dean, New York, Bkn.,	1903
Low, E. C.	Plattsburgh,	1878
Lutze, Frederick H.	403 Jefferson Ave., New York, Bkn.,	1904
Mack, G. B.	34 Lewis, Auburn,	1907
MacCallum, John H.	401 Monroe Ave., Rochester,	1890
Macfarland, R. L.	53 Clinton Ave., New York, Jamaica,	1898
MacKenzie, John A.	Lima,	1902
Martin, L. A.	177 Washington, Binghamton,	1892
Martin, T. J.	279 North, Buffalo,	1891
Maycock, B. J.	145 North, Buffalo,	1893
McDowell, Chas.	117 W. 12th, New York, Mhn.,	1888
McDowell, Geo. W.	1 West 34th, New York, Mhn.,	1893
McDuffie, M. V.	571 Park Ave., New York, Mhn.,	1907

McGeoch, R. L.	Goshen,	1901
McGraw, D. H.	96 Court, Binghamton,	1899
McKown, W. J.	335 Hamilton, Albany,	1895
McMichael, A. R.	969 Madison Ave., New York, Mhn.,	1891
McMichael, D. A.	67 W. 96th, New York, Mhn.,	1892
McPherson, P. J.	Montour Falls,	1899
Mead, Walter Glover	244 W. 104th., New York, Mhn.,	1902
Merriam, H. E.	Owego,	1894
Milbank, W. E.	111 State, Albany,	1879
Miller, Carlos J.	White Plains,	1894
Miller, James D.	70 W. 52d, New York, Mhn.,	1904
MILLER, R. E. (1898)	Oxford,	1871
Mills, Walter Sands	324 W. 89th, New York, Mhn.,	1900
Minton, H. B.	165 Joralemon, New York, Bkn.,	1888
MITCHELL, J. J. (1904)	242 Montgomery, Newburg,	1880
Mitchell, Roy E.	State Hospital, Middletown,	1904
MOFFAT, JOHN L. (1903)	1136 Dean St., New York, Bkn.,	1883
Moore, Arthur S.	State Hospital, Middletown,	1905
Moore, Samuel B.	261 W. 81st, New York, Mhn.,	1904
Morgan, John A.	18 Woodsworth Ave., Yonkers,	1905
Moseley, G. T.	202 Delaware Ave., Buffalo,	1891
Mosher, Charles L.	Chatham,	1904
Mossman, N. A.	Station N., Box 11, 69th and Broadway, New York, Mhn.,	1892
Mott, O. H. (Lic.)	Fort Edward,	1897
Mount, Garry	South Butler,	1907
Mowbray, J. Lincoln	Walton,	1905
Muller, Chas. W.	209 E. 87th, New York, Mhn.,	1907
Muller, Joseph H.	160 E. 63rd, New York, Mhn.,	1903
Muncie, E. H.	119 Macon, New York, Bkn.,	1890
Muncie, Libbie H.	119 Macon, New York, Bkn.,	1896
Munson, Edwin Sterling	104 E. 60th, New York, Mhn.,	1903
Nash, E. B.	Port Dickinson,	1885
Nead, W. M.	205 State, Albany,	1891
Neefus, P. Wyckoff	124 East Ave., Rochester,	1896
Newman, Louis G.	Brewster,	1901
Nickelson, W. H.	Adams,	1889
Nichols, Frank I.	53 Hamilton Av., White Plains,	1907
Noble, E. H.	410 E. Church, Elmira,	1894
Norton, A. B.	16 W. 45th, New York, Mhn.,	1886
Nottage, Rachel R.	669 Macon, New York, Bkn.,	1900
O'Connor, J. T.	Garden City,	1889
Ogden, G. S.	641 E. 28th, New York, Bkn.,	1898
Ormes, Cornelius F.	Jamestown,	1905
Ostrom, H. I.	42 W. 48th, New York, Mhn.,	1886
Otis, J. C.	319 Mill, Poughkeepsie,	1883
Page, Roy A.	Geneseo,	1895
Paige, H. Worthington	Oneonta,	1892
Paine, Chas. E.	653 St. Mark's Av., N. Y., Bkn.,	1905
Pallister, S. W.	688 Nostrand Av., N. Y., Bkn.,	1907
Palmer, A. Worrall	254 W. 57th, New York, Mhn.,	1899
Pardee, M. Clifford	157 Pulaski, New York, Bkn.,	1904
Parsons, Thomas	213 Alexander, Rochester,	1896
Partridge, B. S.	East Bloomfield,	1889
Pattee, Raymond	Broadway, Fort Edward,	1903
Pearsall, W. S.	59 West 90th, New York, Mhn.,	1895
Peckham, Alva Lawrence	31 Cannon, Poughkeepsie,	1903
Peckham, Allen G.	52 Third, Waterford,	1903
Peckham, Hattie C. Van Buren	150 Halsey, New York, Bkn.,	1895
Peters, G. Hoffman	Gloversville,	1905
Perrin, William	308 West Ave., Rochester,	1905
Pettet, Isabella M.	308 E. 15th, New York, Mhn.,	1897
Pettet, Edwin J. de Leu	308 E. 15th, New York, Mhn.,	1904

Pettit, A. R.	Patchogue,	1891
Phillips, R. Oliver	Yonkers,	1891
Phillips, R. E.	21 Park Ave., Rochester,	1898
Pierce, Willard Ide	64 W. 126th, New York, Mhn.,	1890
Pierron, H. J.	438 Greene Ave., New York, Bkn.,	1890
Pierson, W. H.	101 McDonough, New York, Bkn.,	1891
Porter, E. H.	181 W. 73d, New York, Mhn.,	1888
Potter, Clarence A.	Gowanda State Hom. Hospital,	1899
Powel, Milton	163 W. 76th, New York, Mhn.,	1902
Powelson, A. P.	2303 Seventh Ave., New York, Mhn.,	1897
Preston, H. G.	68 Greene Ave., New York, Bkn.,	1875
Price, Wm. A.	801 Prospect Pl., N. Y., Bkn.,	1904
PROCTOR, W. H. (1904)	28 E. First, Corning,	1881
Queen, L. A.	201 W. 79th, New York, Mhn.,	1895
Rabe, Fredk. E.	227 W. 42d, New York,	1906
Rabe, Rudolph F.	616 Madison Av., N. Y., Mhn.,	1903
Rambo, W. S.	43 Plymouth, Rochester,	1892
Randall, Edw. C.	Waterville,	1906
Ranken, John F.	852 Park Pl., New York, Bkn.,	1902
Rankin, Egbert C.	226 W. 59th, New York, Mhn.,	1904
Raymond, H. Lester	Fort Ann,	1904
Raynor, G. F.	1730 Washington Av., N. Y., Mhn.,	1904
Reed, J. A.	3 Maple Court, Newark,	1901
Richardson, Arthur H.	55 E. 93d, New York, Mhn.,	1901
Richardson, A. J.	39 E. 83d, New York, Mhn.,	1890
Richardson, G. W.	138 E. 79th, New York, Mhn.,	1899
Ricker, Mrs. M. S.	58 Lorimer, Rochester,	1890
Rieger, Joseph	509 Central Ave., Dunkirk,	1899
Rink, Walter S.	124 McDonough, New York, Bkn.,	1900
Riordan, P. D.	1047 Livingston Av., N. Y., Mhn.,	1907
Ritch, A. M.	711 Putnam Ave., New York, Bkn.,	1891
Ritch, Orando S.	337a Macon, New York, Bkn.,	1889
Ritchie, F. G.	238 W. 73d, New York, Mhn.,	1894
Robbins, Frederick C.	State Hom. Hospital, Gowanda,	1904
Roberts, D. J.	New Rochelle,	1889
Roberts, G. W.	170 W. 59th, New York, Mhn.,	1891
Robinson, N.	89 Halsey, New York, Bkn.,	1890
Rockefeller, H. O.	152 Jerome, New York, Bkn.,	1892
Roder, Lizzie B.	587 E. 136th, New York, Mhn.,	1904
Rodgers, Albert H.	Corning,	1898
Roe, J. F.	25 Main, Binghamton,	1807
Roper, Frederick E.	73 Broad, Norwich,	1890
Rounds, W. E.	110 W. 40th, New York, Mhn.,	1889
Rowley, C. A.	Victor,	1890
Royal, T. C.	Ballston Spa,	1888
Rudderow, E. D.	148 W. 87th, New York, Mhn.,	1896
Russell, H. Everett	254 W. 76th, New York, Mhn.,	1892
Sampson, Allen W.	43½ Clinton Av. S., Rochester,	1907
Sanders, Harold A.	775 Washington Av., N. Y., Bkn.,	1907
Sanders, L. J.	213 Alexander, Rochester,	1897
Schall, J. Hubley	115 St. Mark's Pl., N. Y., Bkn.,	1901
Schenck, H. D.	75 Halsey, New York, Bkn.,	1887
Schley, J. M.	528 Fifth Ave., New York, Mhn.	1889
Schley, R. Montfort	State Hospital, Gowanda,	1904
Schonger, A. H.	North Branch,	1903
Schwartz, C. W.	Whitehall,	1905
Schumann, C.	Delhi,	1892
Scott, W. H.	786 DeKalb Ave., New York, Bkn.,	1888
Scott, Robert C.	Fulton,	1905
Scudder, N. C.	104 W. Liberty, Rome,	1898
SEARLE, W. S. (1894)	224 Henry, New York, Bkn.,	1865
Seitz, F. B.	21 North, Buffalo,	1897
Severance, B. W.	Gouverneur,	1897

Severance, K. J.	Keeseville,	1906
Seward, F. W.	Goshen,	1891
Seward, F. W., Jr.	Goshen,	1901
Seward, John Perry	200 W. 70th, New York, Mhn.,	1902
Seymour, G. W.	Westfield,	1883
Sharkley, Thornton M.	394 Genesee St., Rochester,	1906
Shaw, J. C.	Hoosick Falls,	1885
Shedd, P. W.	1318 Brooks Ave., N. Y., Mhn.,	1904
Sheldon, Burt B.	104 E. 60th, New York, Mhn.,	1903
Shelton, G. G.	Ridgefield, Conn.,	1886
Shepard, G. A.	"Glenmore", 7th Ave. & 55th, New York, Mhn.,	1892
Shepard, H. G.	521 Monroe Ave., Rochester,	1906
Sherman, Emma S.	69 W. 104th, New York, Mhn.,	1905
Sherman, LeRoy B.	325 W. 14th, New York, Mhn.,	1902
Sherwood, Bradford Wyckoff	1117 S. Salina, Syracuse,	1901
Shrewsbury, William J.	148 Van Buren, N. Y., Bkn.,	1907
Simmons, D.	1188 Dean, New York, Bkn.,	1884
SIMMONS, SILAS S. (1906)	Susquehanna, Penn.,	1885
Simonds, E. A.	Carthage,	1902
Simonson, J. T.	46 W. 85th, New York, Mhn.,	1901
Skinner, S. W.	Le Roy,	1887
Slaught, J. E.	Warsaw,	1883
Smith, F. R.	89 Plymouth Ave., Rochester,	1893
Smith, Geo. H., Jr.	758 Greene Ave., Brooklyn,	1902
Smith, Geo. H.	921 Greene Ave., Brooklyn,	1902
Smith, St. Clair	25 W. 50th, New York, Mhn.,	1891
SMITH, T. F. (1894)	264 Lenox Ave., New York, Mhn.,	1871
Snodgrass, J. Elmer	14 Grover, Auburn,	1905
Snow, S. R.	267 Alexander, Rochester,	1893
SNYDER, E. E. (1904)	27 Main, Binghamton,	1883
SOUTHWICK, A. B. (1898)	Rome,	1871
SOUTHWICK, D. E. (1898)	Ogdensburgh,	1867
Spencer, T. D.	24 Union, S., Rochester,	1884
SPOOR, D. E. (1905)	1128 State St., Schenectady,	1883
Spoor, W. D.	116 Lafayette, Schenectady,	1904
Sprague, E. Russell	200 Rich, Syracuse,	1905
Stanton, L. M.	152 W. 57th, New York, Mhn.,	1895
Stearns, Guy B.	119 W. 82nd, New York, Mhn.,	1905
Stearns, G. R.	201 Linwood Ave., Buffalo,	1893
Stewart, J. A.	1030 Bedford Ave., N. Y., Bkn.,	1892
Stewart, Ralph Alexander	616 Madison Ave., N. Y., Mhn.,	1903
STILES, HENRY R.	Hillview,	1885
Storer, J. H.	30 Edgecomb Ave., N. Y., Mhn.,	1892
Street, H. E.	98 Brooklyn Ave., New York, Bkn.,	1894
Stumpf, D. B.	693 Ellicott, Buffalo,	1885
Sumner, C. R.	33 Clinton Ave., S., Rochester,	1882
Sweeting, W. H.	Savannah,	1890
Swett, Emily F.	Medina,	1892
Swift, C. Frederick	121 Owasco, Auburn,	1905
Swift, Charles L.	266 Seymour St., Auburn,	1905
Swift, E. P.	170 W. 88th, New York, Mhn.,	1888
Sword, G. P.	Huntington, L. I.,	1900
Teets, C. E.	353 Fifth Ave., New York, Mhn.,	1880
TERRY, M. O. (1902)	Mamaroneck,	1876
Thatcher, E. P.	Main St., Newark,	1893
Thomas, Philip Cook	243 W. 99th, New York, Mhn.,	1904
Thompson, Nelson W.	State Hosp., Middletown,	1906
Thompson, V.	322 W. 23d, New York, Mhn.,	1888
Thorpe, Jarvis L.	Clyde,	1902
Thurber, T. J.	137 Plymouth Ave., Rochester,	1889
Towne, Herbert L.	12 Gillespie, Schenectady,	1904
Townsend, Irving	62 W. 51st, New York, Mhn.,	1891

Townsend, Richard E.	Ansonia Hotel, N. Y., Mhn.,	1907
Travers, Osmond J.	85 Phila St., Saratoga Springs,	1902
Trotter, R. R.	Yonkers,	1890
Turner, Reeve	208 E. 72d, New York, Mhn.,	1903
Turner, T. S.	2 Doubleday, Binghamton,	1897
Tuttle, E. G.	61 W. 51st, New York, Mhn.,	1892
Tuttle, Ella M.	New Berlin,	1905
Tytler, G. E.	113 W. 126th, New York, Mhn.,	1889
Tytler, James E.	2051 Fifth Ave., New York, Mhn.,	1906
Upham, Roy	316 McDonough, New York, Bkn.,	1907
Van den Burg, W. H.	30 W. 48th, New York, Mhn.,	1897
Van Derwerker, H. W.	Sandy Hill,	1897
Van Loon, A. B.	198 State, Albany,	1894
Van Ostrand, D. G.	Candor,	1899
Van Schoonhoven, C. S.	698 Putnam Av., New York, Bkn.,	1902
Van Zandt, Wm. M.	164 W. 97th, New York, Mhn.,	1903
Vehslage, S. H.	136 W. 70th, New York, Mhn.,	1891
Vibbard, Arthur A.	223 State, Albany,	1901
Vincent, Stanley	262 Main, Catskill,	1899
Vosburg, Walter H.	309 Lion St., Dunkirk,	1906
Von Bonnewitz, Orlando R.	143 W. 122nd, New York, Mhn.,	1902
Von der Lühe, Augustus	115 Reid Ave., New York, Bkn.,	1883
Wage, John F.	414 Seneca, Buffalo,	1903
WALDO, H. L. (1906)	1834 Fifth Ave., Troy,	1879
Wallace, Joseph C.	Turin,	1906
Walmsley, Robert F.	491 Putnam Av., New York, Bkn.,	1907
Walrad, C. B.	21 N. Broadway, Johnstown,	1889
Walsh, James	Cortland,	1905
Ward, C. A.	33 Court, Binghamton,	1890
Warner, A. G.	19 Schermerhorn, New York, Bkn.,	1888
Warner, F. P.	Canandaigua,	1803
Wasson, Thomas A.	Elizabethtown,	1905
Watson, F. C.	Cazenovia,	1904
WATSON, W. H. (1891)	270 Genesee, Utica,	1869
Welch, C. D.	Castleton,	1907
Wemmel, A. Andrew	2600 Atlantic Ave., New York, Bkn.,	1902
Wetmore, J. McE.	43 W. 54th, New York, Mhn.,	1892
White, A. Genevieve	58 Lorimer St., Rochester,	1906
White, Benjamin Richard	Honeoye Falls,	1902
Whitehorne, Frederick N.	22 W. 123d, New York, Mhn.,	1905
Wiggins, T. C.	520 Nostrand Ave., N. Y., Bkn.,	1894
Wight, Lucy O.	220 W. 130th, New York, Mhn.,	1905
Wilcox, DeWitt G.	597 Elmwood Ave., Buffalo,	1887
Wilcox, Sidney F.	41 W. 52d, New York, Mhn.,	1891
Willcox, Geo. W.	Hamilton,	1902
Wiley, Otis M.	1700 So. Salina St., Syracuse,	1905
Williams, F. F.	6 Goodrich, Canton,	1892
Williamson, B.	Friendship,	1893
Willis, H.	569 Monroe, New York, Bkn.,	1892
Wilson, Isabella M.	Middletown,	1905
Wilson, John E.	616 Madison Av., New York, Mhn.,	1903
Winans, William W.	420 Monroe Ave., Rochester,	1906
Winchell, W. B.	137 Berkeley Pl., New York, Bkn.,	1889
Winslow, James M.	Cold Spring,	1905
Winters, Chas. S.	107 Court, Binghamton,	1902
Wolcott, E. H.	57 Union, Rochester,	1886
Wood, Robert Lowell	129 Hancock, New York, Bkn.,	1907
Woodman, Robert C.	Middletown,	1900
Woodruff, A. J. (retired)	Patchogue,	1891
Wright, Amelia	Ridge Road, Glens Falls,	1902
Wright, J. G.	363 Eleventh, New York, Bkn.,	1900
Young, Jno. R.	Liverpool,	1907
Zimmerman, E. R.	Waterloo,	1905

DIRECTORY

OF THE

HOMŒOPATHIC PRACTITIONERS

OF THE

STATE OF NEW YORK.

JANUARY, 1908.

---

*Regular Member of State Society.
‡Member of County Society.

All who notice errors in the directory will confer a favor upon the profession at large by promptly sending corrections and additions to

H. WORTHINGTON PAIGE,
Secretary.

Oneonta, New York.

The directory this year shows 1248 homeopathic doctors in 330 towns of 59 counties, distributed as follows:

‡Albany	22	‡Jefferson	17	Richmond	4
Allegany	7	‡Kings	180	Rockland	3
‡Broome	18	Lewis	2	St. Lawrence	15
Cattaraugus	9	Livingston	11	Saratoga	11
Cayuga	15	‡Madison	8	Schenectady	10
Chautauqua	18	‡Monroe	89	Schuyler	5
Chemung	10	‡Montgomery	5	Seneca	4
‡Chenango	7	Nassau	2	Steuben	11
Clinton	2	‡New York	325	Suffolk	11
Columbia	7	Niagara	15	Sullivan	3
Cortland	9	Oneida	19	Tioga	10
Delaware	3	‡Onondaga	39	Tompkins	18
‡Dutchess	12	‡Ontario	14	Ulster	8
Erie	51	‡Orange	27	Warren	8
Essex	5	Orleans	5	Washington	14
Franklin	2	‡Oswego	8	Wayne	14
Fulton	6	Otsego	9	‡Westchester	51
Genesee	10	Putnam	4	Wyoming	9
Greene	3	Queens	11	Yates	2
Herkimer	8	Rensselaer	20		

‡County Society.

TOWN INDEX.

Town.	County.
Adams	Jefferson
Afton	Chenango
Akron	Erie
Albany	Albany
Albion	Orleans
Alexandria Bay	Jefferson
Almond	Allegany
Amsterdam	Montgomery
Arcade	Wyoming
Attica	Wyoming
Auburn	Cayuga
Babylon	Suffolk
Baldwinsville	Onondaga
Ballston Spa	Saratoga
Barnard's Crossing	Monroe
Batavia	Genesee
Bath	Steuben
Bay Shore	Suffolk
Beaver Dams	Schuyler
Belfast	Allegany
Belmont	Allegany
Bensonhurst	Kings
Big Flats	Chemung
Binghamton	Broome
Brewster	Putnam
Briar Hill	St. Lawrence
Brighton	Monroe
Brockport	Monroe
Brooklyn	Kings
Brookton	Tompkins
Brownville	Jefferson
Buffalo	Erie
Caledonia	Livingston
Cambridge	Washington
Camden	Oneida
Canandaigua	Ontario
Candor	Tioga
Canisteo	Steuben
Canastota	Madison
Canoga	Seneca
Canton	St. Lawrence
Cape Vincent	Jefferson
Carthage	Jefferson
Castleton	Rensselaer
Catskill	Greene
Cazenovia	Madison
Chatham	Columbia
Chittenango	Madison
Clarence Center	Erie
Clarkson	Monroe

Clayville ..... Oneida
Clifton Springs..... Ontario
Clinton ..... Oneida
Clintondale ..... Ulster
Clyde ..... Wayne
Cohoes ..... Albany
Cold Spring..... Putnam
Cooperstown ..... Otsego
Copenhagen ..... Lewis
Corfu ..... Genesee
Corning ..... Steuben
Cornwall-on-Hudson ..... Orange
Cortland ..... Cortland
Crown Point .. .. Essex
Dansville ..... Livingston
De Kalb Junction.....St. Lawrence
Delhi ..... Delaware
Deposit ..... Broome
DePeyster .....St. Lawrence
De Ruyter ..... Madison
Dobbs Ferry..... Westchester
Dundee ..... Yates
Dunkirk ..... Chautauqua
Eagle Bridge..... Rensselaer
East Aurora ..... Erie
East Bloomfield..... Ontario
East Hamilton..... Madison
East Hamlin..... Monroe
Easton ..... Washington
Elba ..... Genesee
Elbridge ..... Onondaga
Elizabethtown ..... Essex
Ellenville ..... Ulster
Elmira ..... Chemung
Endicott ....Broome
Etna ..... Tompkins
Fairport ..... Monroe
Farmingdale ..... Nassau
Fayetteville ..... Onondaga
Fishkill .....Dutchess
Flushing ..... Queens
Fonda ..... Montgomery
Fort Ann ..... Washington
Forestville ..... Chautauqua
Fort Edward..... Washington
Fort Plain ..... Montgomery
Freeville ..... Tompkins
Fredonia ..... Chautauqua
Frewsburg ..... Chautauqua
Friendship ..... Allegany
Fulton ..... Oswego
Galway ..... Saratoga
Gasport ..... Niagara
Geneseo ..... Livingston
Geneva ..... Ontario
Genoa ..... Cayuga
Glen Cove..... Nassau
Glens Falls..... Warren
Glenhead ..... Nassau
Gloversville ..... Fulton
Goshen ..... Orange
Gouverneur ..... St. Lawrence
Gowanda ..... Cattaraugus
Granville ..... Washington
Greene ..... Chenango
Greenport ..... Suffolk
Greenwich ..... Washington
Groton ..... Tompkins
Hamburg ..... Erie
Hamilton ..... Madison
Hammondsport ..... Steuben
Hartwick ..... Otsego
Hastings-on-Hudson ..... Westchester
Haverstraw ..... Rockland
Hempstead ..... Nassau
Herkimer ..... Herkimer
Heuvelton ..... St. Lawrence
Holland ..... Erie
Homer ..... Cortland
Honeoye Falls..... Monroe
Hoosick ..... Rensselaer
Hoosick Falls..... Rensselaer
Hornell .....Steuben
Hubbardsville .....Madison
Hudson ..... Columbia
Huntington ..... Suffolk
Ilion ..... Herkimer
Ithaca ..... Tompkins
Jamaica ..... Queens
Jamestown ..... Chautauqua
Jay ..... Essex
Johnstown ..... Fulton
Jordan ..... Onondaga
Keeseville ..... Essex
Kingston ..... Ulster
Lebanon Springs ..... Columbia
Le Roy ..... Genesee
Liberty ..... Sullivan
Lilly Dale ..... Chautauqua
Lima ..... Livingston
Little Falls..... Herkimer
Liverpool ..... Onondaga
Livonia ..... Livingston
Livonia Station..... Livingston
Lockport ..... Niagara
Long Island City..... Queens
Lowville ..... Lewis
Ludlowville ..... Tompkins
Lysander ..... Onondaga
Lyons ..... Wayne
Macedon .....Wayne
Madison ..... Madison
Malone ..... Franklin
Mamaroneck ..... Westchester
Margaretville ..... Delaware
Marion ..... Wayne
Massena ..... St. Lawrence
Mayfield ..... Fulton
Mechanicsville ..... Saratoga
Mecklenburgh ..... Schuyler
Medina ..... Orleans
Medway ..... Greene
Memphis ..... Onondaga
Mendon ..... Monroe
Mexico ..... Oswego
Middleport ..... Niagara

Middletown ..... Orange
Milbrook ..... Dutchess
Mohawk ..... Herkimer
Monticello ..... Sullivan
Montour Falls ..... Schuyler
Moores Mills .....Dutchess
Moravia ..... Cayuga
Morris ..... Otsego
Mount Kisco..... Westchester
Mt. Morris..... Livingston
Mount Vernon ..... Westchester
Naples ..... Ontario
Nelsonville ..... Westchester
Newark ..... Wayne
New Berlin..... Chenango
New Brighton..... Richmond
Newburgh ..... Orange
New Paltz..... Ulster
New Rochelle..... Westchester
New Scotland..... Albany
New York ..... New York
Niagara Falls ..... Niagara
North Branch..... Sullivan
North Brookfield..... Madison
North Granville ..... Washington
North Tonawanda ..... Niagara
North Tarrytown ..... Westchester
Norwich ..... Chenango
Norwood ..... St. Lawrence
Nunda ..... Livingston
Nyack ..... Rockland
Ogdensburg ..... St. Lawrence
Olean ..... Cattaraugus
Oneida ..... Madison
Oneonta ..... Otsego
Ossining ..... Westchester
Oswego ..... Oswego
Otego ..... Otsego
Owasco ..... Cayuga
Owego ..... Tioga
Oxford ..... Chenango
Palmyra ..... Wayne
Patchogue ..... Suffolk
Patterson ..... Putnam
Pavilion ..... Genesee
Peekskill ..... Westchester
Penfield ..... Monroe
Penn Yan..... Yates
Perry ..... Wyoming
Phelps ..... Ontario
Philadelphia ..... Jefferson
Phœnix ..... Oswego
Pittsford ..... Monroe
Plattsburgh .....Clinton
Port Chester..... Westchester
Port Dickinson .....Broome
Port Gibson..... Ontario
Port Jervis..... Orange
Potsdam ..... St. Lawrence
Poughkeepsie ..... Dutchess
Randolph ..... Cattaraugus
Redwood ..... Jefferson
Rhinebeck ..... Dutchess
Richfield Springs..... Otsego
Richmond Hill .....Queens
Riverhead ..... Suffolk
Rochester ..... Monroe
Rome ..... Oneida
Rosendale ..... Ulster
Salamanca ..... Cattaraugus
Salisbury Center..... Herkimer
Salem ..... Washington
Salt Point..... Dutchess
Sandy Hill ..... Washington
Saranac Lake..... Franklin
Saratoga Springs..... Saratoga
Saugerties ..... Ulster
Savannah ..... Wayne
Schenectady ..... Schenectady
Scott ..... Cortland
Seely Creek..... Chemung
Seneca Falls..... Seneca
Sherburne ..... Chenango
Shortsville ..... Ontario
Shrub Oak..... Westchester
Silver Creek..... Chautauqua
Skaneateles ..... Onondaga
Sodus ..... Wayne
South Butler..... Wayne
South Byron ..... Genesee
Southampton ..... Suffolk
Southold ..... Suffolk
Spafford ..... Onondaga
Spencertown ..... Clinton
Springville ..... Erie
Springwater ..... Livingston
Stillwater ..... Saratoga
Syracuse ..... Onondaga
Tarrytown ..... Westchester
Theresa ..... Jefferson
Tonawanda ..... Erie
Tottenville ..... Richmond
Trenton ..... Oneida
Troy ..... Rensselaer
Trumansburg..... Tompkins
Tully ..... Onondaga
Turin ..... Lewis
Unadilla ..... Otsego
Union ..... Broome
Utica ..... Oneida
Victor ..... Ontario
Walden ..... Orange
Walton ..... Delaware
Walworth ..... Wayne
Wappingers Falls..... Dutchess
Warners ..... Onondaga
Warsaw ..... Wyoming
Warwick ..... Orange
Washingtonville ..... Orange
Waterford ..... Saratoga
Waterloo ..... Seneca
Watertown ..... Jefferson
Waterville ..... Oneida
Watervliet ..... Albany
Watkins ..... Schuyler
Waverly ..... Tioga

Wayland ..... Steuben
Webster ..... Monroe
Weedsport ..... Cayuga
Wellsville ..... Allegany
West Edmeston ..... Otsego
Westfield ..... Chautauqua
West Henrietta..... Monroe
West New Brighton.....Richmond
West Salamanca..... Cattaraugus
Whitehall ..... Washington
West Winfield..... Herkimer
White Plains..... Westchester
Whitney's Point..... Broome
Williamson ..... Wayne
Wilson ..... Niagara
Wolcott ..... Wayne
Woodhaven ..... Kings
Yonkers ..... Westchester
Yorkshire ..... Cattaraugus

OPENINGS FOR PRACTICE.

The Secretary recently addressed a communication to several physicians in each county of the State, asking for corrections of and additions to, the Directory of Homeopathic Physicians published in this volume; with a supplementary request to be informed of desirable openings for practice. His replies yielded the following. Those desiring further information are advised to address a member of the Society in the nearest center to the town mentioned.

OPENINGS.

Town.	County.
Bath	Steuben
Churchville	Monroe
Dundee	Yates
Cuba	Allegany
Watertown	Jefferson
Ogdensburg	St. Lawrence
Newfane	Niagara
Newark Valley	Tioga
Liberty	Sullivan
Camden	Madison
So. New Berlin	Chenango
Ovid	Seneca
Corning	Steuben
Elmira	Chemung
Tioga	Tioga, Pa.

NO HOMŒOPATHIC PHYSICIAN.

(Formerly had one.)

Town.	County.
Ausable Forks	Essex
Essex	Essex
Ticonderoga	Essex
Ontario	Wayne
Matteawan	Dutchess
Antwerp	Jefferson
Gasport	Niagara
Central Bridge	Schoharie
Union Springs	Cayuga
Marcellus	Onondaga
East Hamilton	Madison

ALBANY COUNTY.

Annual Meeting, Albany, second Thursday in January.

ALBANY.
*Bailey, C. L., 273 Clinton Ave.
‡Blessing, Elmer A., 157 Hamilton.
*‡Carroll, Stephen H., 234 State.
*Cochrane, H. D., 59 Eagle.
‡Congdon, J. B., 664 Central Ave.
*‡Cox, Edward G., 261 State.
*‡Cox, Frederick J., 109 State.
*‡Cox, Geo. A., 80 S. Swan.
*‡Dowling, J. Ivimey, 223 State.
*‡Gorham, G. E., 218 State.
*‡Hunting, Nelson, 155 Hamilton.
*Kinne, Brayton E., 50 Eagle.
*‡McKown, Wm. J., 335 Hamilton
Marshall, B. E., 168 Central Ave.
*‡Milbank, W. E., 111 State.
*‡Nead, W. M., 205 State.
Schwilk, Elisha T., 238 Clinton Av
*‡Van Loon, Arthur B., 198 State.
*Vibbard, Arthur A., 223 State.
COHOES.
Mott, Albert, 242 Saratoga.
*‡Campbell, Wm. M., 176 Remsen.
NEW SCOTLAND.—‡Fitch, J. H.
WATERVLIET.
Van Denbergh, Fred P., 220 23d.

ALLEGANY COUNTY.

No Society.

ALMOND.—Farnum, Llewellyn D.
BELFAST.—*Chamberlain, J. H.
Todd. W. S.
BELMONT.—*Hardy, Wm. J.
Paul, W. K.
FRIENDSHIP.
*Williamson, Bemsley F.
WELLSVILLE.—*Gish, C. L.

BROOME COUNTY.

Annual Meeting, Binghamton, third Wednesday in June.

BINGHAMTON.
‡Bailey, D. P., 41 Court.
*‡Corwin, Elizabeth, 104 Main.
*Harris, George F.
*‡Jenkins, Geo. H., 139 Main.
*‡Martin, Lynn A., 177 Washington.
*‡McGraw, DeWitt H., 96 Court.
*‡Roe, J. F., 25 Main.
*‡Snyder, E. E., 27 Main.
‡Stoutenburg, A. W., 15 Main.
*Turner, T. S., 2 Doubleday.
*‡Ward, Charles A., 33 Court.
‡Ward, W. F., 33 Court.
*‡Winters, C. S., 122 Court.
ENDICOTT.—*Bishop, F. M.
Potter, Raymond.
PORT DICKINSON.—*Nash, E. B.
UNION.—Knapp, Theodore P
WHITNEY'S POINT
Pellette, A. H.

CATTARAUGUS COUNTY.

No Society.

GOWANDA.
*Zwetsch, J. D., 23 Main.
OLEAN.
*Hibbard, DeVere M., 128 S. Union
*Jepson, Mary B., 124 Hamilton.
RANDOLPH.—Babcock, A. H.
SALAMANCA.—Martin, O. S.
Bourne, Philip K.
YORKSHIRE.—Sovereign, Baxter

CAYUGA COUNTY.

No Society.

AUBURN.
Babbitt, Otis H., 178 Genesee.
*Baker, A. E., 55 Franklin.
Bresee, Chas. H., 100 E. Genesee
*Heartwell, W. B., 78 Genesee.
Hitchcock E. W., 167 Genesee.
Hyatt, F. M., 49 E. Genesee.
*Mack, G. B., 34 Lewis.
Robinson, Robt. W., 30 Court.
*Snodgrass, J. Elmer, 14 Grover.
*Swift, Chas. L., 266 Seymour St.
*Swift, C. Fred., 121 Owasco.
GENOA.—Skinner, J. W.
MORAVIA.—Cook, Wm. C.
OWASCO.—Ford, N. B.
WEEDSPORT.—*‡Barnes, C. F.

CHAUTAUQUA COUNTY

No Society.

DUNKIRK.
*Rieger, Jos., 509 Central Ave.
*Vosburg, W., 309 Lion.
FORESTVILLE.—Record, H. A.
FREDONIA.—*Couch, Asa S.
Dods, A. Wilson.
*Prish, J. W.
FREWSBURG.—Lockwood, Benj. F.
JAMESTOWN.
Morgan, Laura.
Neville, Henry
Ormes, F. D., 320 Main.
*Ormes, C. F., 408 West 5th St.
*Robbins, A. J., 304 Main St.
Scott, John W., 222 Winsor.
Ward, Alva F.
Young, A. D.
LILLY DALE.—Hyde, E. C.
SILVER CREEK.—*Cole, W. W.
WESTFIELD.—*Seymour, G. W.

CHEMUNG COUNTY.

No Society.

BIG FLATS.—Davis, D. L.
ELMIRA.
*Adriance, F. W., 306 Lake.
*Eddy, Ermina C., 500 William.
*Everett, Edw. A., 861 College Ave.
*Gregory, G. W., 370 W. Church.
*Howland, Reeve B., 306 Lake.
Jenks, R. B., 300 W. Church.
*Noble, E. H., 410 E. Church.
Thorn, Sarah Eddy.
SEELY CREEK.—Robbins, A. F.

CHENANGO COUNTY.

Annual Meeting, third Tuesday in January; Semi-Annual, third Tuesday in June.

AFTON.—C. W. Hakes.
GREENE.—*Guy, C. N.
NEW BERLIN.—*‡Tuttle, Ella M.
NORWICH.
*‡Roper, F. E., 73 Broad.
OXFORD.—*‡Miller, R. E.
*‡Ganow, G. J.
SHERBURNE.—*‡Little, Wm.

CLINTON COUNTY.

PLATTSBURGH.—Farnsworth, F. S.
*Low, Elliot C., Margaret, corner Cornelia.

COLUMBIA COUNTY.

No Society.

CHATHAM.—*Clark, Mary E.
*Mosher, Charles L.
HUDSON.—*Cook, C. P.
Curran, S. C.
Tracy, A. M.
LEBANON SPRINGS.
Van Buren, B. L.
SPENCERTOWN.—Mesick, J. C.

CORTLAND COUNTY.

Quarterly Meeting, first Tuesday in January, April, June and October.

CORTLAND.
*Ball, H. J., 18 Tompkins.
*Johnson, H. P., 15 Port Watson.
Santee, E. M., 20 Groton Ave.
Spalding, Julia A., 39 N. Main.
Walsh, Jas., 28 Clinton Ave.
HOMER.
Hinman, Sheldon (retired).
Potter, Leman W., 10 S. Main.
Potter, Winfred L., 10 S. Main.
SCOTT.—Barker, M. C.

DELAWARE COUNTY.

No Society.

DELHI.—*Schumann, Carl.
MARGARETVILLE.
Telford, John W.
WALTON.—*Mowbray, J. L.

DUTCHESS COUNTY.

Annual Meeting, Poughkeepsie, third Tuesday in October.

FISHKILL-ON-HUDSON.
Birdsall, W. G.
MILLBROOK.—‡Jacobus, S. J.
MOORES MILLS.—Hall, Edward J.
POUGHKEEPSIE.
Cadwell, C. T., 285 Main.
Devo, C. Knight, 255 Mill.
*‡Lane, Chas. E., 289 Mill.
*‡Otis, John C., 319 Mill.
*Peckham, A. L., 31 Cannon.
RHINEBECK.
Asher, Rutson E. (Retired.)
‡Godell, J. L.
SALT POINT.—*‡Angel, Milton H.
WAPPINGER FALLS.
‡Baxter, William.

ERIE COUNTY.

No Society.

AKRON.—Parker, Frank D.
BUFFALO.
Babcock, C. W., 416 Grant.
*Beals, Herbert, 188 Franklin.
Bodenbender, Edward G., 660 Walden Ave.
Bodenbender, N. W., 4 W. Parade Ave.
Bull, Alex. T., 184 Franklin.
*Carpenter, A. D., 346 Pennsylvania St.
Carter, P. L., 35 Lafayette Ave.
*Chadwick, J. G., 274 Richmond.
*Cook, J. T., 636 Delaware Ave.
*Critchlow, George R., 505 Norwood Ave.
*Decker, W. M., 1336 Main.
*Erb, Peter, 32-34 Palace Arcade
Frost, H. C., 212 Delaware Ave.
Halbert, J. S., 2485 Main.
Hussey, E. P., 493 Porter Ave.
Hyde, Clarence L., 1022 Fillmore Ave.
Johnson, Maria Nye, 143 Elmwood Ave.
Kendrick, C. N., 2362 Main St
*Lewis, Fred D., 188 Franklin.
*Lewis, F. Park, 454 Franklin.
McCrea, P. A., 448 Franklin.

McClellan, I. A., 28 N. Ashland Avenue.
McGill, W. D., 294 S. Division.
Marcy, W. H., 1148 Main.
*Maycock, B. J., 145 North.
*Moseley, G. T., 202 Delaware Ave.
Parmenter, W. L., 931 Prospect Av.
Reed, Mark E., 359 Hudson St. (retired.)
Roberts, Burt B., 58 Palace Arcade.
Root, Reuben M., 40 Krettner.
Salter, A. E., 988 Broadway.
Seaman, C. W., 276 W. Delevan Avenue.
*Seitz, F. B., 21 North.
*Stearns, G. R., 201 Linwood Ave.
*Stumpf, Daniel B., 693 Ellicott.
*Wage, John F., 414 Seneca.
*Wilcox, DeWitt G., 597 Elmwood Ave.
Wilder, Rose C., 247 W. Utica.
CLARENCE CENTER.
Lehman, J. S.
GOWANDA STATE HOMŒOPATHIC HOSPITAL.
*Arthur, D. H.
*Potter, Clarence A.
*Robbins, Frederick C.
*Schley, Robert M.
EAST AURORA.—Mitchell, A. L.
HAMBURG.—Barnes, Francis.
HOLLAND.—Noble, W. A.
SPRINGVILLE.—Caulkins, Frank.
TONAWANDA.—Blighton, W. V. R.
Simson, John R., 127 Delaware.

ESSEX COUNTY.

No Society.

CROWN POINT.—Eaton, Erwin R.
ELIZABETHTOWN.
*Wasson, T. A.
JAY.—*Baldwin, G. E.
Toby, C. McV. (summer only).
KEESEVILLE—*Severance, Karl J.
*Bond, G. W.

FRANKLIN COUNTY.

MALONE.—Belding, D. K.
SARANAC LAKE.
*Hallock, J. Henry.

FULTON COUNTY.

(‡*Montgomery County Society.*)

GLOVERSVILLE.
Bissell, D. A.
*‡Eisenbrey, E. H.
*‡Garnsey, W. S., 93 N. Main.
*Peters, George H., 129 N. Main.
JOHNSTOWN.—*‡Walrad, C. B.
MAYFIELD.—Ingalls, Gilbert.

GENESEE COUNTY.

No Society.

BATAVIA.
*Baker, John W., 22 Bank.
*Conklin, R. C., 72 Main.
*Hutchins, H. S., 215 E. Main.
*LeSeur, J. W., 207 E. Main.
CORFU.—Fawdrey, J. W.
ELBA.—Lewis, J. M.
LEROY.
*Skinner, Scott W., 12 Myrtle.
Skinner, M. R.
PAVILION.—Haway, Geo. Clapp.
SOUTH BYRON.—Whiton, Alpha M

GREENE COUNTY.

No Society.

CATSKILL.
*Goodrich, F. W., cor. Main and William.
*Vincent, Stanley, 371½ Main.
MEDWAY.—Collins, D. E.

HERKIMER COUNTY.

(‡*Oneida County Society.*)

FOURTH LAKE (Old Forge P. O.) Sherwood, B. W. (summer only).
HERKIMER.—Kelly, Erwin E.
‡Kern, E. G.
ILION.—Rude, E. W.
LITTLE FALLS.—‡Brainard, L. L.
MOHAWK.—Landt, Wm.
SALISBURY CENTER.
Wood, E. Hamlin.
WEST WINFIELD.—Spencer, H. J

JEFFERSON COUNTY.

Annual Meeting, Watertown, third Wednesday in November.

ADAMS.—*‡Nickelson, W. H.
ALEXANDRIA BAY.
Campbell, E. E.
*Cole, J. D.
July, Louis E.
Lukens, C. M.
BROWNVILLE.—‡Gates, R. F.
CAPE VINCENT.—Bushnell, H. N
CARTHAGE.—‡Simonds, C. A.
*‡Simonds, E. A.
PHILADELPHIA.—Ryan, M. N.
REDWOOD.—‡Ryan, J. E.
THERESA.—‡Santway, F. L.
Dresser, E. Dell.
Schnell, A. E.
WATERTOWN.—Adams, M. M.
‡Farmer, G. S.
Flint, W. J.
‡Gifford, G. A.

KINGS COUNTY.

Annual Meeting, 44 Court St., Brooklyn, second Tuesday in January.

BENSONHURST (Long Island).
*Bartlett, C. W., 167 Bay 28th.
NEW YORK, BROOKLYN BOROUGH.
*‡Allen, Emma T. P., 461 Washington Ave.
*‡Allen, Herbert C., 304 Clermont Ave.
‡Aten, Wm. H., 100 Greene Ave.
*‡Avery, E. W., 16 Hancock.
*‡Baker, Jennie V. H., 512 Bedford Ave.
Barnes, Roxana K., 195 Garfield Pl
Barnum, Fred'k L., 798 Bedford Ave.
*‡Baylies, B. L'B., 418 Putnam Ave.
*‡Bedford, E. R., 437 Putnam.
*‡Bierbauer, B. W., 47 Pierrepont.
Bishop, Gertrude G., 475 Madison.
Blackman, Mrs. Lora, 519 Clinton Ave.
*‡Blackman, W. W., 519 Clinton Ave.
‡Bolan, L. W., 392 Putnam Ave.
*‡Bornmann, Alfred, 229 Madison.
Brant, Cornelia C., 91 Macon.
‡Breck, William B., 235 Garfield Pl
‡Brinkerhoff, A. S., 544 Monroe.
‡Broughton, L. D., Jr., 418 Madison
Brown, Annie M., 155 Halsey.
‡Brown, Charles A., 155 Halsey.
*‡Bryant, W. C., 66 Greene Ave.
Bulmer, Geo. W., 1210 Bushwick Ave.
‡Burnette, Katherine D., 423 Green Ave.
*‡Burnham, Clark, 182 Clinton.
*‡Butler, W. M., 507 Clinton Ave.
‡Buys, Thos. A., 707 St. John's Pl.
Caldwell, Frank E., 119 Henry.
Cameron, Elizabeth W. M., 530 Clinton Ave.
Campbell, Alice B., 435 Putnam Ave.
Campbell, Jno. B., 435 Putnam Av
‡Cardozo, Jacob L., 223a Monroe.
Carr, H. L., 856 Lafayette Ave.
Cassidy, Georgia A., 1815 Beverly Road.
*‡Chamberlin, W. T., 305 Sixth Ave.
*‡Chapin, Edward, 21 Schermerhorn
‡Chaplain, F. T., 330 E. 18th St.
Clarke, M. Elizabeth, 8 Lafayette Ave.
Clapp, L. H., 510½ Sixth Ave.
*‡Close, Stuart, 209 Hancock.
Cornell, Geo. B., 137 Seventh Av.
*‡Cort, Lottie A., 89 Division Ave.
Crane, Chas. F., 483 E. Seventh.
‡Damon, N. L., 4810 Grant.
Devol, Edmund M., 127 Milton.
Deyo, J. T., 369 Ninth.
Dickie, Perry, 17 Schermerhorn.
‡Diehl, W., Jr., 150 Cornelia.
‡Durrin, Wm. C., 411 Greene Ave.
Eden, Samuel, 1340 Bushwick Ave.
*‡Elliott, Amos H., 480 Monroe.
*‡Fiske, E. R., 1172 Dean.
Fleckles, Mary Fish, 181 Putnam Avenue.
‡Fox, Jas. W., 5019 Fourth Ave.
*‡Freeman, W. H., 263 Arlington Av.
Gerrie, James, 357 Halsey.
*‡Given, James B., 463 Ninth.
*‡Gorton, D. A., 64 Montague.
‡Hadley, C. H., 1312 54th St.
‡Hale, Harriet W., 5 Glenada Pl.
‡Hobby, Ada T., 56 Putnam Ave.
Hoffman, Henry, 139 Prospect Park, W.
‡Hopke, F. Edw., 232 Greene.
‡Hopper, M. T., 46 S. Oxford.
Houghton, B. L., 702 St. Mark's Ave.
*‡Iler, G. H., 243 McDonough.
*‡Ingalls, O. D., 421 Halsey.
*‡Iszard, W. R., 149 St. Mark's Av.
James, A. L., 149 Grove.
*‡Jeffery, G. C., 343 Jefferson Ave.
*‡Johnston, C. L., 467 Vanderbilt Ave.
‡Johnston, R. T., 851 Marcy Ave.
*‡Kastendieck, T. W., 665 St. Marks Ave.
Keep, J. Lester, 460 Clinton Ave.
Klenk, Sophie G., 170 S. Oxford.
‡Knapp, H. J., 287 South Fifth.
Lassen, Helene S., 152 Henry.
‡Latimer, W. C., 305 6th Ave.
‡Lauer, Chas. F. 256 Putnam Ave.
*‡Lazarus, Geo. F., 10 Caton Ave.
‡Lines, Mary L., 285 Washington Ave.
*‡Lloyd, R. I., 450 Ninth.
*‡Love, Wm. L., 1188 Dean.
‡Lowe, Evelyn, 56 Putnam.
*‡Lutze, F. H., 403 Jefferson Ave.
‡Martineau, S. Katherine, 309 Clinton.
Martino, R. R., 792 Madison.
‡McDonald, W. O., 519 5th St.
‡McLenathan, W. H., 101 Division Ave.
Mead, Byron E., 443 Pacific.
Mills, E. F., 244 Hewes.
‡Minshull, Frances E., 130 Halsey.
*‡Minton, Henry B., 165 Joralemon.
*‡Moffat, John L., 1136 Dean.
‡Monmonier, J. L., 480 Classon Ave
‡Moon, W. W., 488 Nostrand Ave.

*‡Muncie, E. H., 119 Macon.
*‡Muncie, Mrs. L. H., 119 Macon.
*‡Nottage, Rachel R., 669 Macon.
*‡Ogden, G. S., 641 E. 28th.
‡Onderdonk, Emma, 104 South Elliott Place.
*Paine, Chas. E., 653 St. Mark's Avenue.
*‡Pallister, Stanley W., 688 Nostrand Ave.
‡Palmer, A. J., 90 Hancock.
‡Palmer, G. H., 92 Hancock.
Palmer, Warren B., 360 Hancock.
*‡Pardee, M. C., 157 Pulaski.
Patton, James H., 201 Skilman.
‡Pearse, Richard S., 322 Van Siclen Ave.
*‡Peckham, Hattie C. Van Buren, 150 Halsey.
Perveil, A. C., 14 Hancock.
*‡Pierron, H. J., 438 Greene Ave.
Pierson, W. B., 162 Macon.
Pierson, W. H., 101 McDonough.
‡Potter, Mary E., 290 DeKalb Ave.
*Preston, H. G., 54 Greene Ave.
*Price, Wm. A., 801 Prospect Pl.
Price, W. H., Prospect Heights Hospital.
‡Purmort, G. Jennie, 130 Halsey.
Quinn, W. J., 668 Greene Ave.
*‡Ranken, J. F., 852 Park Pl.
Rankine, Isabella M., 43 Lee Ave.
‡Richards, Mary E., 213 Keap.
‡Richardson, B. M., 151 Milton.
Reigelman, Mrs. Laura M. Long, 43 Lee Ave.
‡Rink, Wm. E., 301 E. 16th.
*‡Rink, Walter S., 124 McDonough.
*‡Ritch, A. M., 711 Putnam Ave.
*‡Ritch, Orando S., 337a Macon.
*‡Robinson, Nathaniel, 89 Halsey.
Robinson, W. B., 261 Crescent.
*‡Rockefeller, H. O., 152 Jerome.
Rose, H. W., 1238 Bushwick Ave.
*Sanders, H. A., 775 Washington Avenue.
*‡Schall, J. H., 115 St. Mark's Pl.
*‡Schenck, H. D., 75 Halsey St.
‡Schlegel, Louise, 472 Willoughby Ave.
*Scott, W. H., 786 DeKalb Ave.
*‡Searle, W. S., 224 Henry.
Seeley, W. W., 109 Sixth Ave.
*‡Shrewsbury, W. J., 148 Van Buren.
*‡Simmons, D., 1188 Dean.
Simon, S. H., 515 E. 24th.
‡Sisson, Mabel C., 360 Greene Av.
Slee, H. C., 191 Jefferson Ave.
*Smith, G. H., 921 Greene Ave.
*‡Smith, G. H., Jr., 758 Greene Ave.
‡Smith, Sidney E., 78 Arlington Av.
Spooner, E. H., 767 Putnam Av.
Squire, Alice A., 345 Fifth Ave.
‡Stafford, Fred E., 20 Hancock.
Stephenson, B. S., 116 Montague.
*‡Stewart, J. A., 1030 Bedford Ave.
‡Stolz, Rosalie H., 778 Putnam Ave.
Straley, May W., 282 Halsey.
*‡Street, H. E., 98 Brooklyn Ave.
‡Sutton, John J., 514 Willoughby.
‡Thompson, J. M., 386 Clinton.
‡Thompson, W. C., 226 Ross.
‡Turton, M. Louise, 360 Greene Av.
*‡Upham, Roy, 316 McDonough.
Van Arnam, Annie B., 136 Monroe
Van Kleek, J. H., 707 Union.
Van Mater, G. G., 682 Greene Av.
*‡Van Schoonhoven, C. S., 698 Putnam Ave.
*‡Von der Luhe, Augustus, 115 Reid Ave.
Walters, Chas. A., 111 Milton.
*‡Walmsley, R. F., 491 Putnam.
*‡Warner, Alton G., 19 Schermerhorn
*‡Wemmel, A. A., 2600 Atlantic Av.
*‡Wiggins, T. C., 520 Nostrand Av.
Willis, Clinton, 494 Putnam Ave.
*Willis, H., 569 Monroe.
*‡Winchell, W. B., 137 Berkeley Pl.
*‡Wood, Robt. L., 129 Hancock.
Woolley, Charlotte H., 676 Prospect Pl.
*‡Wright, Justus G., 363 Eleventh.
Zimmerman, Florence, 414 Bainbridge.

WOODHAVEN.—(Long Island.)
‡Casselberry, J. L.

LEWIS COUNTY.

(‡*Jefferson County Society.*)

COPENHAGEN.—*Hall, C. B.
TURIN.—*Wallace, Joseph C.

LIVINGSTON COUNTY.

No Society.

CALEDONIA.—*Borden, G. T.
Cole, D. D.
DANSVILLE.
*Andrews, B. P., 103 Main.
GENESEO.—*Page, Roy A.
Southall, E. W.
LIMA.—*Mackenzie, John A.
LIVONIA.—Bettis, J. T.
LIVONIA STATION.
Trimmer, W. S.
MOUNT MORRIS.—Leach, A. E.
NUNDA.—*Ostrander, P. M.
SPRINGWATER.
*Knickerbocken, Herbert D.

MADISON COUNTY.

Annual Meeting, Oneida, fourth Tuesday in June.

CANASTOTA.—*Deuel, W. E.
CAZENOVIA.—*Watson, F. C.
Keppel, Fred D.
CHITTENANGO.—*Deuel, W. E.
De RUYTER.—‡Coon, E. N.
HAMILTON.—*‡Willcox, G. W.
HUBBARDSVILLE.—York, J. T.
MADISON.—‡Gifford, Barton R.
NORTH BROOKFIELD
York, G. T.
ONEIDA.—‡Wallace, J. T.

MONROE COUNTY.

Annual Meeting, Rochester Homœopathic Hospital, second Tuesday in December.

BRIGHTON.—Wheeler, J. P.
CLARKSON.—Hermance, S. C.
EAST HAMLIN.—Darrow, S. W.
FAIRPORT.—*‡Clapp, W. F.
*Clapp, George.
Otis, Clark.
‡Price, George S.
HONEOYE FALLS.—
*White, Benj. R.
MENDON.—Guyott, E. J.
PENFIELD.—Humphrey, N. M.
PITTSFORD.—*‡Davis, Arthur E.
ROCHESTER.
*‡Adams, Myron, H., 56 Park Av.
*‡Adams, R. A., 418 Powers Bldg.
‡Anderson, H. A., 391 West Ave.
‡Bachman, G. A., 720 South Ave.
*‡Baker, H. H., 301 Lake Ave.
‡Bascom, F. T., 67 So. Fitzhugh.
*‡Beck, E. G. H., 694 Clinton Ave. N.
‡Bidwell, G. I., 75 Clinton Ave. S.
Biegler, J. A., 58 Clinton Ave. S.
*‡Bissell, E. J., 75 South Fitzhugh.
Brownell, W. G., 122 North.
*‡Buell, Jesse W., 67 Chestnut.
*‡Button, L. L., 265 Alexander.
‡Carman, W. B., 32 Upton Park.
*Carter, G. A. B., 10 Cumberland.
Chaffee, D. J., 8 Clinton Ave.
Chamberlayne, Mrs. Louise F., 16 State.
*‡Clapp, C. R., 427 Hayward Ave.
*‡Collins, N. M., 43 East Ave.
‡Cook, E. B., 293 Monroe Ave.
Curtis, W. H., 855 Main St. E.
‡Dake, W. E., 98 Clinton Ave. N.
‡Daly, W. C., 371 University Ave.
*Doane, W. H., 75 Clinton Ave. S.
Earle, E. W., 55 Monroe Ave.
‡Fowler, W. F., 63 Clinton Ave.
*‡Fowler, W. P., 63 Clinton Ave. S.
Fritz, A. R., 28 Draper.
‡Graham, M. E., 1100 South Ave.
*Grant, R. C., 823 South Ave.
Haines, A. D., 2 Asbury.
‡Haywood, Julia F., 612 West Ave.
*Hermance, A. C., 611 St. Paul.
Hoard, V. A., 637 Main, East.
*‡Hoyt, Herbert W., 33 So. Clinton Ave.
‡Hoyt, Mrs. Mary M., 225 Culver Road.
*Jewett, D. B., 68 Clinton Ave., S.
*‡Johnson, W. W., 17 East Ave.
*‡Keegan, W. A., 40 Clinton Ave., S.
*‡Kellogg, C. M., 49 Chestnut.
*‡Lee, J. M., 179 Lake Ave.
*MacCallum, John H., 408 Monroe Ave.
McCullough, Alice S., 19 Laburnam.
‡Morgan, Jno., 49 Park Ave.
Morton, Pauline, 173 University Av.
*‡Neefus, P. W., 124 East Ave.
Otis, C. F., 75 Clinton Ave. So.
*‡Parsons, Thomas, 215 Alexander.
*Perrin, William, 308 West Ave.
Perrine, C. W., 76 Clifton.
*Phillips, R. E., 200 Alexander.
Proctor, J. C., 29 Buckingham.
*‡Rambo, W. S., 43 Plymouth.
*‡Ricker, Mrs. M. S., 58 Lorimer.
Ross, E. V., 279 Jefferson Ave.
*Sampson, Allen W., 43½ Clinton Avenue S.
*‡Sanders, L. J., 213 Alexander
Sayles, Emma S., 13 Park Ave.
*Sharkley, Thornton M., 394 Genesee St.
*‡Shepard, H. G., 520 Monroe Ave.
Smith, E. C., 135 Plymouth Ave.
*‡Smith, F. R., 89 Plymouth Ave.
*‡Snow, S. R., 267 Alexander.
‡Sooy, J. W., 62 Clinton Ave. So.
*‡Spencer, T. D., 24 S. Union.
‡Stillwell, F. W., 62 University Ave.
*‡Sumner, C. R., 33 Clinton Ave. S.
Thompson, G. M., 94 East Ave.
*‡Thurber, T. J., 129 S. Fitzhugh.
‡Tretton, J. K., 601 Lake Ave.
‡Van Allan, R. A., 234 Monroe Ave.
Wadsworth, Robert, 176 State.
*White, A. Genevieve, 58 Lorimer St.
Willis, F. L. H., 243 Alexander.
*‡Winans, W. W., 421 Monroe Av.
*‡Wolcott, E. H., 57 South Union.
WEBSTER.—‡Whittleton, E. J.
WEST HENRIETTA.
‡Walker, C. E.

MONTGOMERY COUNTY.

Annual Meeting at Fonda, second Wednesday Quarterly Meetings.

AMSTERDAM.
*‡Frazier, L. A., 124 Division.
*‡Hicks, H. M.

FONDA.—Foster, A. B.
FORT PLAIN.—Jackson, John C.
‡Zoller, Wm.

NASSAU COUNTY.

No Society.

GLEN COVE.
*Ginnever, Arthur, Glen Cove.
HEMPSTEAD.
*Lount, Robert, 245 Fulton.

NEW YORK COUNTY.

(MANHATTAN AND BRONX BOROUGHS.)

Annual Meeting, second Thursday in December, at Genealogical Hall.

Adams, Mary I., 408 Central Park West.
*‡Allen, J. Wilford, 117 W. 12th.
*‡Allen, Paul, 3 E. 48th.
*‡Ambler, J. Edgar, 102 E. 26th.
‡Andrew, R. M., 245 W. 123rd.
‡Arschagouni, John, 138 W. 21st
Atkins, L. R., 106 W. 96th.
‡Austin, A. E., 616 Madison Ave.
*‡Bagg, C. L., 26 W. 46th.
‡Baker, C. R., 70 W. 55th.
*‡Baldwin, J. G., 8 East 41st.
Baldwin, Mary H., 274 Third Ave.
‡Barber, Edward H., 201 W. 78th
‡Barber, Addie B., 201 W. 78th.
Barker, Caleb, 57 W. 95th.
Baruch, Emanuel, 57 E. 77th.
Baruch, Solomon, 136 E. 76th.
Bassett, J. S., 11 West 31st.
‡Beals, M. B., 133 W. 123rd.
‡Bennett, J. A., 2101 Fifth Ave.
*‡Benson, Reuel A., 8 W. 49th.
Bergerson, Emma C., 466 W. 140th.
*‡Berghaus, A., 160 W. 92d.
‡Bickford, Lydia A., 12 W. 39th.
‡Bigelow, A. J., 163 E. 106th.
‡Bingham, A. H., Euclid Hall, B'way & 86th.
*‡Bishop, Wm. H., 667 Madison Ave.
Blakeman, J. L., 1977 Seventh Ave.
‡Boyce, Alice A., 934 Ogden Ave.
*‡Boyle, C. C., 49 W. 37th.
*‡Boynton, F. H., 36 West 50th.
‡Bren, M. R., 132 W. 111th.
Brigham, H. C., 107 Central Pk. W.
‡Broder, M. E., 81 2d St.
*‡Brown, Chester R., Metropolitan Hospital.
‡Brown, G. C., 56 West 45th.
*‡Brown, M. Belle, 30 W. 51st.
*‡Buchanan, T. D. 210 W. 57th.
*‡Buchholz, Louise Z., 73 St. Mark's.
Buckwalter, J. A., 178 W. 89th.
‡Burt, James E., 251 W. 81st.
Butterworth, Mary, 415 W. 118th
Cahoon, Elizabeth, 110 W. 84th.
Cahoon, J. H., 253 W. 22d.
Campbell, Annie S., Jerome Ave. and 163d.
‡Campbell, C. E., 212 Lenox Ave.
‡Cannon, M. D., 131 W. 122d.
*‡Carleton, B. G., 75 W. 50th.
‡Carleton, E., 71 W. 50th.
‡Carleton, Spencer, 71 W. 50th.
*‡Carleton, Sprague, 75 W. 50th.
‡Chapman, A. E., 108 W. 69th.
*Charles, Emily C., 51 W. 127th.
*‡Chase, J. O., 214 East 53d.
Clapp, L. H., Flower Hospital.
*Clark, B. B., 166 W. 126th.
*‡Clark, B. G., 25 W. 74th.
Clock, Sarah A., 2193 Broadway.
Cocheu, L. F., 256 W. 57th.
*‡Cole, Hills, 1748 Broadway.
*‡Cole, Harlan P., 1748 B'way.
‡Cole, Lewis Gregory, 616 Madison Ave.
*Coleman, D. E. S., 101 W. 78th.
Conklin, Chas. R., 168 E. 62d.
Cooke, Mrs. H. N. F., 1145 Park Ave. (retired.)
‡Cossart, A. B., 1378 Lexington Av.
*‡Crump, W. G., 837 Madison Ave.
Darrach, May, 126 W. 104th.
*‡Danforth, L. L., 49 W. 52d.
Daniels, J. L., 167 W. 126th.
*Davies, Thos. F., 359 W. 116th.
Davis, Jane C., 1575 Bathgate Ave.
*‡Davis, J. E. L., 743 Madison Ave.
*‡Deady, Chas., 151 W. 73d.
*‡Dearborn, Fred'k M., 855 Seventh Avenue.
Decker, J. W., 515 Madison Ave. (Retired.)
*‡Delabarre, W. E., 212 W. 45th.
*‡Demarest, J. H., 59 W. 126th.
*Dieffenbach, W. H., 1748 Broadway
*‡Dillingham, T. M., 8 W. 49th.
*‡Dillow, George M., 223 W. 57th.
*‡Dominick, G. C., 70 W. 55th.
*‡Dowe, F. Le C., 2973 Bainbridge Ave.
Dowkonitt, Geo. H., 90 Madison.
*‡Dowling, J. W., 56 W. 50th.
‡Du Jardin, Roland, 1103 Lexington Ave.
‡Duncan, C. A., 233 Lexington Av.
‡Dunlevy, Rita, 328 W. 57th.
‡Edmonston, Elizabeth, 36 W. 25th.
‡Edwards, Mary L., 19 W. 46th.
*Eife, Arthur F., 175 W. 10th.
‡Embley, T. W., 213 E. 21st.
‡Emery, Mary E., 107 W. 82d.
Ferrier, Jas. M., 1841 Madison Av.
Fleming, W. L., 174 St. Nicholas Ave.

Fletcher, Addison C., 250 W. 135th.
*‡Fobes, J. H., 222 W. 59th.
*‡Foote, Mary E. B., 122 Lexington Ave.
*Fralick, W. G., 991 Madison Ave.
*‡Franklin, E. D., 368 Convent Av.
‡Franklin, L. E., 355 W. 14th.
‡Frech, Edwina, 19 W. 101st St.
‡Gaines, J. S., 163 W. 91st
Gardner, Dr., 201 E. 23rd St.
Garrison, H. W., 154 E. 86th.
*‡Garrison, J. B., 115 E. 71st.
*‡Gennerich, Chas., 71st & B'way.
Gilbert, C. E., 323 W. 23d.
Goode, J. N., 727 E. 140th.
‡Goodrich, S. W., 507 W. 152d.
*‡Gore, Jennie E., 1145 Park Ave.
*‡Hallett, G. D., 128 W. 85th.
Hallock, Frank M., 106 Central Park W.
‡Hamlin, F. W., 130 W. 48th.
Hanchett, H. G., 40 W. 85th. (Retired.)
‡Hardy, J. T., 164 W. 74th.
Hardy, S. O., 925 West End Ave.
‡Harrington, Gove S., 487 W. 145th.
‡Harris, James E., 2000 Lexington.
Harris, James W., 229 E. 124th.
*‡Hartley, W. G., 335 W. 34th.
*‡Hassler, J. W., 112 W. 72d.
*‡Hathaway, H. S., 146 W. 92d.
*‡Helfrich, C. H., 569 Fifth Ave.
*‡Helmuth, W. T., 26 E. 62nd.
*‡Higbie, Annie S., 158 W. 76th.
*‡Hill, Emily L., 207 W. 84th.
‡Hinkley, Abbie G., 128 W. 43rd.
*‡Hollister, F. K., 521 Madison.
*‡Honan, W. F., Broadway and 70th.
House, Wallace B., 203 W. 113th.
*‡Howard, C. C., 57 W. 51st.
*‡Howe, J. M., 12 W. 46th.
‡Hoyt, E. F., 39 W. 58th.
Hughes, D. Zane, 322 W. 42d.
Hughes, Harriet, 151 W. 82nd.
‡Hull, G. A., 123 W. 73d.
*‡Hunt, D. B., 5 W. 82nd.
*‡Hutchinson, John, 75 E. 55th.
Husson, John, 418 W. 124th.
‡Jarrett, Elizabeth, 1 W. 101st.
Johnson, E. K., 109 W. 129th.
Jones, Mary H., B'way & 73d.
*Jones, Robt. M., 161 W. 47th.
Jones, W. H., Broadway and 73rd.
*Kaufman, L. R., 256 W. 57th.
‡Keatinge, Mrs. H. C., 102 W. 75th.
‡Keatinge, Harriette d'E., 102 W. 75th.
‡Keep, Mrs. C. J. Y., 308 W. 36th.
‡Kellogg, E. W., 111 E. 56th.
*‡King, W. Harvey, 616 Madison Avenue.
‡Kidder, Hugh, 305 W. 46th.
‡Klots, E. D., 724 Columbus.
*‡Krause, W. H., 61 E. 86th.
Lacina, A. M., 346 E. 72nd.
*‡Laidlaw, A. H., 58 W. 53rd.
*‡Laidlaw, G. F., 58 W. 53rd.
*‡Land, J. F., 40 W. 127th.
*Lannin, Louise, 1 W. 82nd.
*‡Leal, Malcolm, 171 W. 73rd.
Lewis, N. H., 18 W. 35th.
‡Lischner, Ayman, 311 E. 10th.
‡Lund, F., 2 W. 86th.
‡MacBride, N. L., 4 E. 43d.
‡Mack, Gertrude, 408 Central Pk.
*‡Macy, C. S., 103 W. 71st.
*‡Maeder, J. G., 304 East 120th.
‡Matteson, N. D., 16 Central Pk. West.
Mayer, Henriette O., 1381 Boston Road.
‡McDonald, R. E., 28 W. 128th.
*‡McDowell, Chas., 117 W. 12th.
*‡McDowell, Geo. W., 1 West 34th.
*‡McDuffie, M. V., 571 Park Ave.
McIntosh, S. D., 155 W. 80th.
MacIvor, Jas. H., 699 E. 140th.
*‡McMichael, A. R., 969 Madison Ave.
*‡McMichael, D. A., 67 W. 96th.
‡McNight, W. C., 219 W. 135th.
‡Meyers, Harriet, 150 E. 60th.
Mickle, J. B., Metropolitan Hosp.
*‡Miller, J. D., 70 W. 52d.
Miller, Eli P., 39 W. 26th.
Miller, John F., 324 W. 57th.
*‡Mills, Walter S., 324 W. 89th.
‡Miner, F. C., 1134 Forest Ave.
‡Mitchell, Chas. A., 2026 Seventh Ave.
*‡Moore, S. B., 261 W. 81st.
Morgan, G. E., 69 W. 130th.
Morgan, John A., 130 W. 134th.
*‡Mossman, N. A., Station N., Box 11, 69th and Broadway.
Mount, Margaret A. B., 572 Lexington Ave.
*‡Müller, C. W., 209 E. 87th.
*Müller, Jos. H., 160 E. 03rd.
*‡Munson, E. S., 104 E. 60th.
‡Newcomb, Wm. H., 147 W. 105th.
*‡Norton, A. B., 16 W. 45th.
‡Novenski, Anna M., 519 W. 185th.
‡Nutter, Mary E., 242 E. 50th.
‡Oberbeck, A., 305 E. 55th.
‡O'Brien, Evelina C. D., 1381 Boston Road.
‡O'Brien, W. S., 1239 Franklin Av.
*‡O'Connor, J. T., 7 W. 42d.
*‡Ostrom, H. I., 42 W. 48th.
*‡Palmer, A. W., 254 W. 57th
‡Palmer, Helen C., 253 W. 103d.
‡Palmer, John B., 21 E. 24th.
‡Palmer, Miles W., 235 E. 18th.

‡Pardee, E. B., 74 W. 48th.
Parkhurst, Burleigh, 348 W. 58th.
‡Patchen, G. H., 147 W. 23rd.
*‡Pearsall, W. S., 59 W. 90th.
Peason, Mary C., 415 W. 115th.
‡Pelham, M. A., 198 W. 120th.
*‡Pettet, Isabella M., 308 E. 15th.
*‡Pettet, E. J. de Leu, 308 E. 15th.
*‡Pierce, W. Ide, 64 W. 126th.
Piersons, A. M., 24 E. 127th.
*‡Porter, E. H., 181 W. 73d.
‡Powel, Ella L., 163 W. 76th.
*‡Powel, Milton, 163 W. 76th.
*Powelson, Arthur P., 2303 7th Ave.
*‡Queen, L. A., 201 W. 79th.
*‡Rabe, F. E., 227 W. 42d.
*‡Rabe, Rudolph F., 616 Madison Ave.
*‡Rankin, E. G., 226 W. 59th.
Raynor, Geo. F., 1730 Washington Ave.
Read, A. S., 157 W. 51st.
Read, W. A. 46 W. 83d.
‡Richardson, A. H., 55 E. 93d.
*‡Richardson, A. J., 39 E. 83d.
*‡Richardson, G. W., 138 E. 79th.
*‡Riordan, P. D., 1047 Lexington Avenue.
*‡Ritchie, F. G., 238 W. 73d.
Roberts, Eugene P., 252 W. 53d.
*‡Roberts, G. W., 170 W. 59th.
Robinson, J. L., 130 E. 165th.
*‡Roder, Lizzie B., 587 E. 136th.
Rosenfeld, B. A., 257 E. 71st.
‡Rounds, Irene, 105 E. 15th.
*‡Rounds, W. E., 110 W. 49th.
‡Royle, Sinclair K., 105 W. 76th.
*‡Rudderow, E. D., 145 W. 88th.
*‡Russell, H. E., 254 W. 76th.
‡Scheel, Sophia B., 970 Park Ave.
*Schley, J. M., 528 Fifth Ave.
Schroeder, M. E. O., 229 Hancock.
‡Sewall, S. G., 130 W. 123rd.
*‡Seward, J. Perry, 200 W. 70th.
Seward, F. W., 200 W. 70th.
*‡Shedd, P. W., 1318 Brooks Ave.
‡Sheldon, F. P., 223 W. 122d.
*‡Sheldon, B. B., 104 E. 60th.
*‡Shelton, G. G., 521 Madison.
*‡Shepard, G. A., The Glenmore, 7th Ave. and 55th.
*‡Sherman, Emma S., 69 W. 104th.
‡Sherman, Irving P., 59 W. 90th.
‡Sherman, L. B., 325 W. 14th.
Sibley, C. T., 117 W. 12th.
‡Simonson, J. T., 46 W. 85th.
Sinsabaugh, J. A., 672 Second Ave.
‡Sloat, H. G., 40 W. 93d.
‡Smart, Isabella, T., 101 W. 80th.
‡Smith, F. L., 159 W. 48th.
Smith, G. B., 35 E. 28th.
Smith, Nelson, Jr., 151 W. 48th.
‡Smith, Roswell D., 2676 Creston Ave.
*‡Smith, St. Clair, 56 W. 50th.
*‡Smith, T. F., 264 Lenox Ave.
‡Smyth, S. H., 223 E. 19th.
*‡Stanton, L. M., 152 W. 57th.
*‡Stearns, Guy B., 119 W. 82nd.
*‡Stevens, Anna C. R., 247 W. 42d.
‡Stewart, G. T., 14 E. 60th.
Stewart, Margarita, 691 Wendover Ave.
*‡Stewart, Ralph A., 616 Madison Avenue.
‡Stoddard, L. B., 1 W. 82d.
*‡Storer, J. H., 30 Edgecombe Ave.
‡Strader, C. A., 1446 Washington Avenue.
‡*Swift, E. P., 170 W. 88th.
*‡Teets, C. E., 353 Fifth Ave.
*‡Thomas, P. C., 243 W. 99th.
Thompson, J. H., 36 E. 30th.
*‡Thompson, Virgil, 322 W. 23rd.
Tiffany, C. E. B., 11 W. 107th.
Tinker, H. H., 1257 Washington Ave.
*‡Townsend, Irving, 62 W. 51st.
‡Townsend, Katherine G., 144 W. 80th.
‡Townsend, Richard E., Ansonia Hotel.
*‡Turner, Reeve, 208 E. 72d.
*‡Tuttle, E. G., 61 W. 51st.
*‡Tytler, J. E., 2051 Fifth Ave.
*‡Tytler, G. E., 113 W. 126th.
*‡Van den Burg, Wm. H., 30 W. 48th
*Van Zandt, Wm. M., 164 W. 97th.
*‡Vehslage, S. H., 136 W. 70th.
‡Ver Nooy, Chas., 146 W. 64th.
*‡Von Bonnowitz, O. R., 143 W. 122d
*‡Vondergoltz, Eric, 247 E. 72d.
‡Walker, B. D., 162 E. 122d.
Wallin, A. C., 468 W. 145th.
‡Webster, C. G., 2973 Bainbridge Avenue.
*‡Wetmore, J. McE., 43 W. 54th.
*‡White, A. Lenora, 111 W. 82d.
‡White, Sarah C., 601 W. 136th.
*‡Whitehorne, F. N., 22 W. 123rd.
Whiteman, J. L., 343 W. 57th.
*‡Whitney, Geo. W., 2366 7th Ave.
*‡Wight, Lucy O., 220 W. 130th.
Wilcox, Emma D., 307 W. 98th.
*‡Wilcox, Sidney F., 41 W. 52nd.
‡Wilder, L. deV., 55 W. 33d.
Wildes, Thos., 610 Lexington Ave.
‡Wilmsky, Eva, 134 E. 94th.
Williams, Cordelia, 31 E. 22nd.
‡Williams, Jean M., 150 W. 104th.
*‡Williams, T. C., 118 E. 19th.
*‡Wilson, John E., 616 Madison Av.
‡Winterburn, G. W., 7 W. 108th.
‡Withington, I. J., 612 W. 136th.

‡Wood, J. Robie, 43 W. 19th.
‡Worrall, M. Ruth, 136 E. 17th.
‡Young, Chas. H., 169 W. 73rd.
Young, F. G., 196 Lenox Ave.

NIAGARA COUNTY.

No Society.

LOCKPORT.
*Blackley, Carl A., 70 Main.
Evans, A. J., 20 Main.
*Hurd, S. Wright, 78 Main.
Pettit, Gaylord J., 135 Main.
Watters, Fowler A., 29 Main.
Weaver, Willis P., 74 Main.
MIDDLEPORT.
Robertson, Mrs. Helen M.
NIAGARA FALLS.
Dumville, H. C., 1028 South Ave.
Gray, John, 1712 Main.
Hodge, John W., 10 Gluck Block.
*Hodge, Wm. H., 8 Gluck Block.
*Hough, Walter D., 635 Main.
Wilson, W. C., 8 Gluck Block.
NORTH TONAWANDA.
Bentley, F. W., 243 Goundry.
WILSON.—Draper, W. L.

ONEIDA COUNTY.

No Society.

CLAYVILLE.—Dewing, W. H.
CLINTON.—‡Dever, I.
ROME.—*Southwick, A. B.
*Scudder, N. C., 104 N. Liberty.
TRENTON.— Spencer, R. S.
UTICA.
*Alliaume, C. E., 18 Clarendon Bld
*Capron, C. G., 1 Hopper.
*Chase, C. E., 137 Park Ave.
Dean, L. W., 40-41 Gardner Bldg
Fairbank, Stuart J., 9 West.
*Gayde, E. A., 189 Lansing.
Guile, E. B., 13-14 Winston Bldg.
*Grant, A. R., 321 Genesee.
*Haines, Charles T., 42-43 Gardner Building.
*Harrison, H. A., 196 Genesee.
Hennessy, Margaret E., 15 Winston Building.
*Johns, M. W., 188 Court St.
*Watson, W. H., 270 Genesee.
WATERVILLE.
*Randall, Edward G.

ONONDAGA COUNTY.

Annual Meeting, Syracuse, first Tuesday in May.

BALDWINSVILLE.-
Heaton, Earl C.
‡Martin, Leslie.
ELBRIDGE.
Kaple, Edward B.
‡Warren, Erastus.
FAYETTEVILLE.—*Badgly, C.
Hutchinson, P.
JORDAN.—Spire, C. E.
LYSANDER.—Doud, F. H.
LIVERPOOL.—‡Young, J. R.
MEMPHIS.—‡Sullivan, N. B.
SKANEATELES.—*Hall, Edwin P.
SPAFFORD.—Barker, G. E.
SYRACUSE.
*‡Candee, J. W., 501 Fayette Pk.
‡Chaffee, R. W., 1626 W. Genesee.
*Church, Herbert A., 601 Warren.
*‡Crowell, L. C., 314 S. Crouse Av.
*‡Du Bois, Willard C., 519 S. Salina.
‡Flint, E. H., 1624 W. Genesee.
*Gannett, G. J., 527 Salina.
*‡Gridley, Geo. L., 408 University Avenue.
*‡Hartman, W. L., 737 University Building.
*‡Hinman, C. E., 114 Slocum.
‡Hooker, Frederick, 117 Kirk Blk
*‡Hoyt, Gordon W., 426 Warren.
*Irish, J. H., 422 James.
‡Keeler, E. E., 452 Salina.
*‡Keese, J. M., 215 Slocum.
*‡Kinne, A. B., 410 Fayette Pk.
*‡Kinne, E. O., 601 Warren.
Leggett, L. S. G., 412 West Onondaga.
‡Putnam, F. B., 104 Harrison.
*Sprague, E. Russell, 200 Rich.
*‡Sherwood, B. W., 1117 S. Salina.
*Wiley, Otis M., 1700 So. Salina.
Willer, A. M., 807 Midland.
TULLY.—Leonard, Wm. H.
WARNER'S.—‡Houston, S. W.

ONTARIO COUNTY.

Annual Meeting, Canandaigua, second Wednesday in October.

CANANDAIGUA.
Brockmyre, M.
‡Mitchell, C. T., 2 Park Pl.
*‡Warner, F. P.
CLIFTON SPRINGS.
*Conley, L. P.
Newland, F. C.
EAST BLOOMFIELD.
*‡Partridge, Barton S.
GENEVA.—*‡Covert, N. B.
*Hopkins, W. W.
*‡Knapp, James C.
NAPLES.—Conley D. C.
PHELPS.—‡Pritchard, G. C.
PORT GIBSON.--Throop, A. P.
SHORTSVILLE.—‡Cooke, J. D
VICTOR.—*‡Rowley, C. A.

ORANGE COUNTY.

Meeting, June 24th, Newburgh.

CORNWALL-ON-HUDSON.
Chandler, David H.
GOSHEN.—*McGeoch, R. L.
*Seward, F. W., Jr.
*Seward, F. W.
MIDDLETOWN.
*Ashley, Maurice C., State Hosp.
*Ballou, Harvey B., State Hosp.
*Barrus, Clara, State Hosp.
*Beers, M. I., 66 E. Main.
*Bingham, Harvey V., State Hosp.
Bradner, Julia A.
*Brewster, Geo. F., State Hosp.
*Fancher, E., 16 Orchard.
Hanmer, J. La T., 51 Highland.
*Mitchell, Roy E., State Hosp.
*Moore, A. S., State Hosp.
Powelson, Howard J., 8 William.
Schultz, E. M., 97 E. Main.
*Thompson, Nelson W., State Hospital.
*Wilson, Isabella M.
*Woodman, R. C., State Hosp.
NEWBURGH.
*Jacobson, F. A., 269 Grand.
Mitchell, J. J., 242 Montgomery.
PORT JERVIS.—*Best, Fred'k W.
Lambert, E. B.
WALDEN.—Faulkner, W. H.
WARWICK.—*Cummins, Frank M.
Cummins, J. Seeley.
WASHINGTONVILLE.
Reed, Wm. E.

ORLEANS COUNTY.

No Society.

ALBION.—Norton, F. R.
Wage, Arnold E.
MEDINA.—*Gillette, Myra A.
Scott, F. W.
*Swett, Emily F.

OSWEGO COUNTY.

Annual Meeting, Oswego, second Tuesday in June.

FULTON.
*‡Haviland, N. H., 224 Oneida.
*‡Scott, Robt. C.
MEXICO.—‡Radway, C. W.
‡Stow, T. D.
OSWEGO.
*‡Albertson, C. S., 9 W. Bridge.
*‡Calisch, A. C., Hotel Redstone.
Hervey, C. R., 33 E. Bridge.
PHŒNIX.—Young, Daniel F.

OTSEGO COUNTY.

No Society.

COOPERSTOWN.—Evans, C. V. S.
Blodgett, T. S.
HARTWICK.—Luce, Daniel.
MORRIS.—Matison, Merritt.
ONEONTA.—Augustin, Geo. W.
*Paige, H. Worthington.
OTEGO.—Payne, C. O.
UNADILLA.—Clark, P. G.
WEST EDMESTON.—Davis, A. C.

PUTNAM COUNTY.

(‡*Westchester County Society.*)

BREWSTER.—*‡Newman, L. G.
Brinkman, Mrs. M. A.
COLD SPRING.
*Winslow, James M.
PATTERSON.—*Birdsall, Thomas P.

QUEENS COUNTY.

(‡*Kings County Society.*)

NEW YORK, FLUSHING.
Allen, Wm. A., Bowne Ave.
*Brennan, Francis E., 445 Amity.
Fox, John J., 192 Amity.
Fox, Robert L., 192 Amity.
NEW YORK, JAMAICA.
Belden, Chas. K., 28 Clinton Ave.
*‡MacFarland, R. L., 53 Clinton Ave
Nobie, Herbert, 49 Union Ave.
Shuttleworth, J. Evan, 188 Shelton Ave.
NEW YORK, LONG ISLAND CITY.
Brennan, F. E., 76 East Ave.
Platt, C. N., 152 Franklin (Astoria)
RICHMOND HILL.
Payne, John A.
OZONE PARK.—Casselberry, J. L.

RENSSELAER COUNTY.

(‡*Albany County Society.*)

CASTLETON.—*‡Welch, C. D.
EAGLE BRIDGE.—Rider, E. H.
HOOSICK.—Donnelly, James H.
HOOSICK FALLS.—Hudson, F. R.
Lamb, G. M.
Putnam, W. B.
*Shaw, J. C.
RENSSELAER.
Miller, Horace C., 78 Broadway.
TROY.
*‡Benson, R. F., Jr., 2 St. Paul Pl.
Belding, R. E., 2141 Fifth Ave.
‡Bloss, Fred S., 70 Second.
Bloss, Jabez P., 108 Second.
Bloss, Richard D., 1810 Fifth Ave.

*Coburn, E. S., 91 Fourth.
Crandall, E. L., 1943 Fifth Ave.
*Green, A. R., 25 Second.
*‡Green, Crawford R., 25 Second.
‡Griffin, Jennie, Pawling Ave.
Holmes, H. P., 512 Second Ave.
*‡Waldo, H. L., 1834 Fifth Ave.

RICHMOND COUNTY.

No Society.

NEW BRIGHTON.
Donovan-Conklin, Fannie C., 48 West.
TOTTENVILLE.—Coleman, David.
WEST NEW BRIGHTON.
(NEW YORK.)
Bryan, William.
Dawley, Lewis B.

ROCKLAND COUNTY.

HAVERSTRAW.—Payne, J. A.
NYACK.—Couch, L. B.
Giles, J. Wm.

ST. LAWRENCE COUNTY.

(‡*Jefferson County Society.*)

BRIAR HILL.—Graves, Fred E.
CANTON.—Russell, G. A.
*Williams, Frank F., 6 Goodrich.
DE KALB JUNCTION.
Cole, E. M.
DE PEYSTER.—Oram, Sara H.
GOUVERNEUR.—*Severance, B.W.
HEUVELTON.—Turner, Jason.
MASSENA.—Stearns, M. J.
NORWOOD.—Sumner, C. Oliver.
OGDENSBURG.
*‡Bell, W. N., 6 Greene.
Child, N. N.
Marsh, James M.
*Southwick, D. E.
POTSDAM.—Botsford, L. T.
Brown, H. D.

SARATOGA COUTY.

No Society.

BALLSTON SPA.—*Royal, T. Cook.
Thayer, Alfred I.
GALWAY.—Ingalls, Gilbert.
MECHANICSVILLE.
Crissey, G. W., Park Ave.
La Dow, Charles H.
Purcell, J. M.
SARATOGA SPRINGS.
Ayres, Mrs. E. F.
*Dennison, R. W.
*Travers, Osmond J.
STILLWATER.—Smith, Sarah N.
WATERFORD.
*Peckham, A. G., 52 Third.

SCHENECTADY COUNTY.

(‡*Albany County Society.*)

SCHENECTADY.
‡Bates, Geo. W., 143 Jay.
*‡Faust, Louis, 19 Jay.
*‡Faust, William P., 22 Jay.
‡Fiske, Katrina C., 536 Liberty.
*‡Fryer, Olin J., 945 State St.
*‡Gillette, Elizabeth, 414 Union.
Liddle, Henry S., 1022 State.
*‡Spoor, D. E., 1128 State.
*‡Spoor, W. D., 168 Lafayette.
*‡Towne, H. L., 820 Union.

SCHUYLER COUNTY.

No Society.

BEAVER DAMS.—Purdy, M. S.
MECKLENBURGH.—Stobbs, A. V.
MONTOUR FALLS.
Clawson, C. D.
*McPherson, P. J.
WATKINS.—King, Geo. H.

(*Southern Society takes in all these counties.*)

SENECA COUNTY.

No Society.

CANOGA.—Frantz, A. J.
SENECA FALLS.—Covert, R. B.
Follet, W. M., 33 Cayuga.
WATERLOO.—*Zimmerman, E. R.

STEUBEN COUNTY.

No Society.

CANISTEO.—Sutton, Frank L.
CORNING.
*Bryan, E. W., 22 W. Erie Ave.
Campbell, C. E., 108 Wall.
Gorton, Wm. E.
*Proctor, W. H., 126 Pine.
Purdy, M. S.
*Rodgers, A. H., 158 Pine.
HAMMONDSPORT.—Horton, J. T.
HORNELL.
Hathaway, W. E., 229 Main.
Truman, I. P., 17 Genesee.
WAYLAND.—Piatt, A. A.

SUFFOLK COUNTY.

BABYLON.—*Foster, Wm. E.
BAY SHORE (Long Island).
King, Geo. S., Maple Ave.
Raymond, H. L.
GREENPORT.—Ireland, T. L.
‡Manaton, W. P.
HUNTINGTON (Long Island).
*Swords, Geo. P.

PATCHOGUE.
*Foster, E. Agate, Ocean Ave.
*Pettit, A. R., Main St.
*Woodruff, A. J. V. (retired).
RIVERHEAD.—Bleecker, Wm. H.
SOUTHAMPTON.—Pierson, John G.
SOUTHOLD.—Hartramft, Joseph.

SULLIVAN COUNTY.

LIBERTY.—*Deady, Howard P.
MONTICELLO.—Meyer, O. N.
NORTH BRANCH.
*Schonger, A. H.

TIOGA COUNTY.

(‡*Broome County Society.*)

CANDOR.—Holley, E. D.
*Van Ostrand, D. G.
OWEGO.—Brown, L. C.
*‡Dutcher, Merritt T.
*‡Greenleaf, J. T.
*Hyde, Louis D.
*Merriam, H. E.
WAVERLY.—Beach, Belle R.
*Gamble, Ellsworth.
Hilton, W. M.

TOMPKINS COUNTY.

BROOKTON.—Reid, D. A.
ETNA.—Rood, Geo. L.
FREEVILLE.—Genung, Homer.
GROTON.—Baldwin, A. M.
ITHACA.
Beaman, C. P., 306 E. Seneca.
*Besemer, H. B., 232 S. Albany.
*Besemer, Martin, 224 S. Albany.
*Crum, H. H., 212 Hazen,
Eadie, Andrew B., 124 E. State.
Griggs, Elma.
Kirkendall, J. S.
Nash, N. W., 119 E. Seneca.
Prentiss, Mrs. Adelina E.
Warren, R. C., 217 Hazen.
LUDLOWVILLE.—*Fish, Wilber G.
TRUMANSBURG.—Terry, David P.
Carpenter, L. W.

ULSTER COUNTY.

No Society.

CLINTONDALE.—*Birdsall, W. G.
ELLENVILLE.—Coles, James C.
KINGSTON.
Chalker, A. P. (Rondout).
Connolly, W. Harry, 98 Fair.
Stelle, L. T., 73 Albany.
NEW PALTZ.—Gerow, Stephen W.
ROSENDALE.—Van Demaark, John.
SAUGERTIES.—Wallace, Wm. I

WARREN COUYTY.

No Society.

GLENS FALLS.
Birdsall, E., Colonia Building.
*Birdsall, S. T., 142 Ridge.
Coffin, Henry W.
*Horton, C. A.
Little, G. W.
Paine, Howard S.
Smith, M. D.
*Wright, Amelia, Ridge Road.

WASHINGTON COUNTY.

No Society.

CAMBRIDGE.—*Clark, L. A.
EASTON.—Mosher, E. E.
FORT ANN.—*Raymond, H. Lester.
FORT EDWARD.
*Mott, O. H. (Lic.)
*Pattee, Raymond.
GRANVILLE.—Mosher, B. D.
GREENWICH.—Hulst, Peter H.
NORTH GRANVILLE.
Tobey, C. M.
SALEM.—Russell, R. G.
SANDY HILL.—Infield, Clifford L.
*Van Derwerker, H. W.
WHITEHALL.—*Horton, Ernest T.
*Schwartz, C. W.
Mosher, E. E.

WAYNE COUNTY.

No Society.

CLYDE.—*Thorpe, Jarvis, L.
LYONS.—Aldrich, Dr.
MACEDON.—Rodenberger, E. M.
MARION.—Halsted, Albert R.
NEWARK.—Barnes, J. W.
*Reed, J. A.
*Thatcher, E. P.
PALMYRA.—McPherson, D.
SAVANNAH.—*Sweeting, W. H.
SODUS.—*Hitchcock, C. T.
SOUTH BUTLER.—*Mount, Garry.
WALWORTH.—Esley, E. E.
WILLIAMSON.—Clark, Frank Wake
WOLCOTT.—Houston, S. Wilson.

WESTCHESTER COUNTY.

Annual Meeting, Yonkers, last Wednesday in October.

DOBB'S FERRY.
*Beattie, Jos. H.
*‡Hasbrouck, Joseph.
HASTINGS-ON-HUDSON.
Curry, Elizabeth S.
White, Storm.
IRVINGTON-ON-HUDSON.
Manifold, A. W. F.

MAMARONECK.—Gerard, Louise.
*‡Hall, Matthew J.
Montgomery, R. W.
*Terry, M. O.
MOUNT KISCO.
*Brown, E. Wilton.
MOUNT VERNON.
*Boynton, L. R., 131 S. 3d Ave.
Davis, Wm. B., 42 Park Ave.
Hardy, A. R., 111 First Ave.
*Hardy, Arthur H., 115 First Av.
House, Jos. Agate, 136 Park Ave.
*‡Ives, Nathaniel H.
Van Denburg, M. W., 107 Union Ave.
NELSONVILLE.—‡Winslow, W. J.
NEW ROCHELLE.—Barker, Caleb.
Chambers, M. G.
‡Finch, E. W., Center Ave. and Prospect.
‡Kellogg, Fannie H., 172 Huguenot.
Pope, Edward S.
*‡Roberts, D. J.
NORTH TARRYTOWN.
*‡Brown, E. V.
OSSINING.
*‡Lane, Irvin J., 26 Maple.
‡Madden, Joel D.
Schafmeister, John A.
PEEKSKILL.
‡Mason, Perley H., 734 South.
*‡Greene, Chas. R. r
PORT CHESTER.
‡White, J. C.
White, J. S.
Elmendorf, T. C., 166 N. Main.
SHRUB OAK.—Dresser, G. D.
TARRYTOWN.
Coles, H. L.
WHITE PLAINS.—*Birch, Cha
Birch, Francis, 191 Railroad
Haight, A. M.
*‡Kingsley, O. D.
*‡Miller, Carlos J.
Nichols, Chas. I.
Nichols, Frank I.
YONKERS.
*Beckwith, S. A., 275 Warbur Avenue.
*Holden, George Parker, 175 W burton Ave.
Jenks, E. B.
*‡Keith, Horace G., 317 S. Broad
*Morgan, J. A., 18 Woodsworth
*Munson, E. S.
*‡Phillips, R. O., 257 Warburton A
Quick, A. V., 86 Warburton A
Stillwell, B. W.
*‡Trotter, R. R., 189 Warburton A

WYOMING COUNTY.

ARCADE.—Hulett, Giles S.
Shedd, B. D.
ATTICA.—*Gifford, W. B.
Warren, S. G.
PERRY.—Brownell, J. R.
Hervey, C. R.
Pierce, Mrs.
WARSAW.—Andrews, L. M.
*Slaught, J. E.

YATES COUNTY.

PENN YAN.—Cox, Joseph T.
Sampson, F. S.

INDEX.

A Case of Manic Depressive Insanity Cured by Arsenicum Album, William Morris Butler - - - - - - - 252
A Dioscorea Villosa Case, Rudolph F. Rabe, - - - - - 274
Address of Welcome, Hon. Bird S. Coler, - - - - 159
A Consideration of the Relationship Which our Materia Medica Bears to the Treatment of Disease, Rudolph F. Rabe, - - - 95
A Homeopathic Physician; Definition of, - - - - - 2
A Few Cases Illustrating the Superiority of Homeopathic Therapeutics, D. E. S. Coleman, - - - - - - - 81
A Legitimate Field for the Specialist, A. Worrall Palmer, - 150
A Lycopodium Case, R. C. Grant, - - - - - - 271
A Neglected Factor in Public Health, Harlan P. Cole, - - 314
Arnica—When Indicated—Compared with Antiseptics, D. E. S. Coleman, - - - - - - - - - 254
Artificial Dilatation of the Cervix—New Hydrodynamic Bag Dilator, "Pomeroy," Geo. Hills Iler, - - - - - - 201
Appendix, - - - - - - - - - - - - 425
A Retrospect—Toast, E. R. Fiske, - - - - - - 439
Arsenic versus Carbolic and the Cresols in Surgery, William H. Freeman, - - - - - - - - - - 258
Are the Violet Rays a Cure for Paralysis? W. E. Milbank, - 108
ASHLEY, M. C., Remarks, - - - - - 106, 307, 332
Attendance Committee, Report of, - - - - - - 14, 195
Auditing Committee, Report of, - - - - - - 14, 175
Banquet; Report of; Toasts, etc., - - - - - - 439
Banquet Committee, Report of, - - - - - - - 20
BAYLIES, B. L. B., Infantile Pneumonia, 246; Remarks, - - 266
Biographical Sketch of President Schenck, - - - - - 429
BIRDSALL, S. T., Remarks, - - - - - - - 63
BISHOP, WILLIAM H., Operation in Two Stages, 110; Remarks, - 384
BISSELL, E. J., Remarks, - - - - - - - 233
BLACKMAN, W. W., Thuja and Hepar in Uterine Fibroids, 248; Remarks, 385
Breathing, Fred D. Lewis, - - - - - - - - 156
BROWN, E. WILTON, Remarks, 290; The Solonaceæ, or Nightshade Family, - - - - - - - - - - 292
BUCHANAN, T. DRYSDALE, Remarks, - - - - - - 389
BUTLER, WILLIAM M., Remarks, 242, 253, 256, 324, 337, 343; A Case of Manic Depressive Insanity Cured by Arsenicum Album, 252; The Homeopathic Treatment of Mental Diseases, - - 337
BUTTERFIELD, ALFRED J., Obituary of, - - - - - 427
BUTTON, LUCIUS L., Remarks, - - - - - - 378
By-Laws, - - - - - - - - - - - 468
CAMERON, ELIZABETH M. W., Remarks, - - - - - 241

Cantharis Vesicatoria in Nephritis, Endocarditis and Pericarditis, Wallace McGeorge, - - - - - - - - 276
Cancer, W. J. Shrewsbury, - - - - - - - 399
Censors, Report of, - - - - - - - 16, 167
Chronological Table of Officers, 1850-1907, - - - - - 474
Circular Letters—Relative to Medical Examining Boards, - - 431
CHASE, C. E., Infantile Malnutrition, - - - - - - 70
Clinical Medicine and Pathology, Bureau of, - - - 33, 344
Clinics at the Cumberland Street Hospital, - - - - - 418
Clinic; Major Surgical, W. H. Pierson, - - - - - - 418
Clinic; Minor Surgical, R. F. Walmsley, - - - - - 419
CLOSE, STUART, Precision in Homeopathic Prescribing, 74; Remarks, 288, 405; Toast, "The Pioneers," - - - - - - 443
COLEMAN, D. E. S., A Few Cases Illustrating the Superiority of Homeopathic Therapeutics, 81; Arnica; When Indicated; Compared With Antiseptics, - - - - - - - - 254
COLE, HILLS, Remarks, 189; The Relation of the Family Physician to the Health Officer, - - - - - - - - 309
COLLINS, NEWTON M., Presidential Address, 9; Remarks, - - 63
COLER, HON. BIRD S., Address of Welcome, - - - - - 159
Clean Milk, Ellis M. Santee, - - - - - - - 299
COLE, HARLAN P., Remarks, 291; A Neglected Factor in Public Health, - - - - - - - - - 314
Committees, 1907-1908, - - - - - - - 5, 6, 7, 8
Committee to Nominate State Medical Examiners, - - - 21
Committee on President's Address, - - - - - - 22
Constitution and By-Laws, - - - - - - - 467
Constitutional Inferiority, Frederick C. Robbins, - - - 98
County Directory, - - - - - - - - 491
CRUMP, WALTER G., Intestinal Obstruction, 195; Remarks, 205, 213, 415
Cystic Degeneration of the Villi of the Chorion; With Report of a Case, and a Specimen, L. L. Danforth, - - - - 207
DALY, WARREN C., The Value of Leucocyte Counts in Surgical Cases, 373
DANFORTH, LOOMIS L., Cystic Degeneration of the Villi of the Chorion, With Report of a Case, and a Specimen, - - 207
DEARBORN, F. M., Report as Treasurer, - - - - - - 13
DECAMP, FRANK H., Obituary of, - - - - - - 425
Definition of a Homeopathic Physician, - - - - - - 2
DE LA MONTANYE, WILLIAM, Obituary of, - - - - - 428
Diagnosis of Appendicitis by Exclusion, O. S. Ritch, - - - 116
Dietetic Methods in the Nutritional and Gastro-Intestinal Diseases of Infancy and Early Childhood, J. T. Simonson, - - 64
Directory of Homeopathic Physicians, - - - - - - 486
DOANE, W. H., Splenic Leukæmia, 146; Remarks, - - - 149
DOWLING, J. IVIMEY, Relation of Nasal Affections to Ocular Diseases, 215; Remarks, 220, 233; Meliotus in Congestive Headaches, - 256
DOUGHTY, FRANCIS E., Obituary of, - - - - - - 426
Election of Officers, - - - - - - - - 23
Election of State Medical Examiners, - - - - - 22
Eleven Successive Cases of Diphtheria, Joseph Hasbrouck, - - 260

Exhibits, Report of Committee on, - - - - - - 21
FAUST, LOUIS, Remarks, - - - - - - - - 204
Fifty-Fifth Annual Meeting; Proceedings of, - - - 9
FISKE, E. RODNEY, Biographical Sketch of President Schenck, 429; Toast, "A Retrospect," - - - - - - - 439
FRANKLIN, E. D., Remarks, - - - - - - - 372
FREEMAN, W. H., Remarks, 250, 253, 263; Arsenic versus Carbolic and the Cresols in Surgery, 258; Medorrhinum, - - 283, 407
Forty-First Semi-Annual Meeting, - - - - - - 159
GARRISON, JOHN B., Rhinitis Vasomotoria Periodica, 238; Staphysagria in Chalazion, - - - - - - - 270
General Paresis and the Family Physician, Robert C. Woodman, - 322
GOODNO, WILLIAM C., Treatment of Acute Infectious Diseases, - 46
GRANT, A. R., The Results of Ventro Suspension, - - - 138
GRANT, R. C., A Lycopodium Case, - - - - - - 271
GREENLEAF, JOHN T., The Control of Cases of Addiction, 107; Remarks, - - - - - - - - 331
Gynæcology, Bureau of, - - - - - - - 133, 399
HOLDEN, GEORGE PARKER, Spinal Curvature, with Special Reference to Nebels' Suspension Frame, and Sciatica, 182; Remarks, 188, 189, 190
HALLETT, G. DEWAYNE, Remarks, - - - - - - 218
HAMLIN, F. W., Remarks, - - - - - - - 206, 212
HARTMAN, W. LOUIS, Shock and its Treatment, 127; Remarks, 128, 130, 132
HASSLER, J. W., Remarks, - - - - - - - 392
HASBROUCK, JOSEPH, Remarks, 237, 240, 242, 250; Eleven Successive Cases of Diphtheria, - - - - - - - - 260
Honorary Members; List of, - - - - - - - 476
HONAN, WM. FRANCIS, The Results of Some Uterine Infections, 139; Surgery and the Public, - - - - - - - 394
HOPKE, F. EDWARD, Remarks, - - - - - - 307
HOWARD, C. C., Remarks, - - - - - - - 106
How to Blow the Nose, Frank B. Seitz, - - - - - 243
HOWLAND, REEVE B., Report of Treasurer, 14, 174; Remarks, - - 195
Hyoscin, Morphin and Cactin Anæsthesia, Chas E. Walton, - - 387
ILER, GEORGE HILLS, Artificial Dilatation of the Cervix—New Hydrodynamic Bag Dilator, "Pomeroy," - - - - - - 201
Increasing Membership, Report of Committee on, - - - 18
Infantile Malnutrition, C. E. Chase, - - - - - - 70
Infantile Pneumonia, B. L. B. Baylies, - - - - - 246
Intestinal Obstruction, Walter G. Crump, - - - - - 195
IRISH, J. HERBERT, The Diaphragm as a Barrier to Infection, - 112
IVES, NATHANIEL H., Rheumatic Conditions in Childhood, - - 191
JEFFERY, GEORGE C., Remarks, - - - - - - 369
Kali Bromide in a Case of Climacteric Insanity, Guy B. Stearns, - 272
KASTENDIECK, J. T. W., Remarks, - - - - - 280, 291
KEITH, HORACE G., Remarks, - - - - - - - 195
KING, WILLIAM HARVEY, Remarks, - - - - - - 354
Lachesis, Nathaniel Robinson, - - - - - - - 265
Lachesis in Purpura Hæmorrhagica and Peliosis Rheumatica, Walter B. Winchell, - - - - - - - - 267

LAIDLAW, GEORGE F., Nervous Dyspepsia, 54; Remarks, 90, 148; Recent Aids in the Diagnosis of Tuberculosis, - - - 358
Laryngology and Rhinology, Bureau of, - - - - 150, 235
LAWRENCE, JEROME B., Obituary of, - - - - - 427
LEONARD, WM. H., Remarks, - - - - - 302, 308
Legislative Committee, Report of, - - - - - 19
LEVERSON, M. R., Remarks, - - - - 290, 306, 370, 408
LEWI, M. J., Remarks, - - - - - - - 349
LEWIS, FRED D., Remarks, 94, 155, 158; Breathing, - - 156
List of Membership, - - - - - - - 476
LOVE, WILLIAM L., Pityriasis Rubra, 263; Medical Clinic, - - 422
LLOYD, RALPH I., The Nasal Sinuses as Routes for Infecting the Mastoid and Meninges, 235; Remarks, - - - - 237
Materia Medica, Bureau on, - - - - - - 74, 246
Medical Examiners, State Board, Report of, - - - - 17
Medical Clinic, William L. Love, - - - - - 422
Medical Examining Boards, Letters Relative to, - - - 431
Meliotus in Congestive Headaches, J. Ivimey Dowling, - - 257
Medorrhinum, W. H. Freeman, - - - - - - 283
Membership, Official List of, - - - - - - 476
Memorial Resolutions, Gov. Frank W. Higgins, Francis E. Doughty, 23
MCDOWELL, CHARLES, Remarks, - - - - 241, 371
MCDOWELL, GEORGE W., Remarks, - - - 219, 233, 269
MCGEORGE, WALLACE, Cantharis Vesicatoria in Nephritis, Endocarditis and Pericarditis, - - - - - - 276
MILBANK, W. E., Are the Violet Rays a Cure for Paralysis? - - 108
Miscellaneous Business, - - - - - - 24, 178
MITCHELL, ROY E., The Tuberculosis Problem in the Hospital for the Insane, 28; Two Cases of General Paresis of Long Duration, - 327
MOAK, HARRIS, Remarks, - - - - - - 305
MOFFAT, JOHN L., Necrologist's Report, 16, 165, 234; Remarks, - 84, 94, 219, 343, 356, 408
MUNCIE, ELIZABETH HAMILTON, Remarks, - - - - 386
NASH, E. B., Remarks, - - - - - - 86, 93
Natrum Muriaticum in Vernal Conjunctivitis, Herbert Dana Schenck, 275
Necrologist, Report of, - - - - - 16, 165, 425
Nervous Dyspepsia, George F. Laidlaw, - - - - 54
NEWTON M. COLLINS, Presidential Address, - - - 9
Neurology, Bureau of, - - - - - - 98, 322
NICKELSON, W. H., Remarks, - - - - - 291, 305
Nomination of Officers, - - - - - - 169
Observations on the Homeopathic Therapeutics of Tuberculosis, Guy B. Stearns, - - - - - - - 86
Obstetrics, Bureau of, - - - - - - - 201
Officers, 1906-1907, 4; 1907-1908, - - - - - 5
Officers, Nomination of, - - - - - - 169
Openings for Practice, - - - - - - 490
Operation in Two Stages, William H. Bishop, - - - 110
Ophthalmology and Otology, Bureau of, - - - - 146, 214
OSTROM, HOMER I., The Backache of Endocervicitis, - - - 133

OTIS, JOHN HAVILAND, Obituary of, - - - - - 428
PAIGE, H. WORTHINGTON, Remarks, - - - - 107, 245
PAINE, CHARLES E., Remarks, - - - - - - 241
PACKARD, HORACE, Remarks, - - - - - 371, 385
Pædiatrics, Bureau of, - - - - - - - 64, 182
PALMER, A. WORRALL, A Legitimate Field for the Specialist, 150; Remarks, - - - - - - - - - 157
PIERSON, W. H., Remarks, 249; Major Surgical Clinic, - - 418
Pityriasis Rubra, William L. Love, - - - - - - 263
POMEROY, RALPH, Remarks, - - - - - - 203
Popular Errors Regarding Nephroptosis, Sidney F. Wilcox, - - 379
Precision in Homeopathic Prescribing, Stuart Close, - - 74
President's Address, Herbert Dana Schenck, - - - - 162
President's Address, Committee Report on, - - - 22
Presidential Address, Newton M. Collins, - - - - 9
Proceedings of Fifty-Fifth Annual Meeting, - - - 9
Proceedings of the Forty-First Semi-Annual Meeting, - - - 159
PRICE, WILLIAM H., X-Ray and Electrical Clinic, - - - 422
Program, Scientific, - - - - - - - - 26
Public Health, Bureau of, - - - - - - - 28, 299
Pyæmia Following Vaccination, O. S. Ritch, - - - - 364
RABE, RUDOLPH F., Remarks, 85, 90, 92, 271, 283; A Consideration of the Relationship Which our Materia Medica Bears to the Treatment of Disease, 95; A Dioscorea Villosa Case, - - 274
Recent Aids in the Diagnosis of Tuberculosis, George F. Laidlaw, - 358
Regular Members, List of, - - - - - - - 477
Relation of Nasal Affections to Ocular Diseases, J. Ivimey T. Dowling, 215
Report of the Auditing Committee, - - - - - 14, 175
Report of Banquet Committee, - - - - - - 20
Report of Committee on Exhibits, - - - - - 21, 169
Report of the Censors, - - - - - - - 16, 167
Report of the Committee on Increasing Membership, - - 18, 167
Report of the Legislative Committee, - - - - 19, 170
Report of the Committee on Local Arrangements, - - - 168
Report of the Committee on Attendance, - - - - 14, 165
Report of the State Board of Medical Examiners, - - - 17
Report of the Press Committee, - - - - - - 169
Report upon the Special Legislative Fund, - - - - 171
Report of the Necrologist, - - - - - - - 16, 165
Report of the Treasurer, - - - - - - - 13, 174
Resolutions Adopted, - - - - - - - - 176
Rhinitis Vasomotoria Periodica, John B. Garrison, - - 238
Rheumatic Conditions in Childhood, Nathaniel H. Ives, - - 191
RITCH, O. S., Diagnosis of Appendicitis by Exclusion, 116; Pyæmia Following Vaccination, 364; Remarks, - - - 371, 393
RITCHIE, FREDERICK G., The Clinical Significance of Ciliary Neuralgia, 220; Remarks, - - - - - - - - 291
ROBBINS, FREDERICK C., Constitutional Inferiority, - - - 98
ROBERTS, GEORGE W., Remarks, - - - - - 130,131
ROBINSON, NATHANIEL, Remarks, 189; Lachesis, - - - 266
RUSSELL, JAMES E., Obituary of, - - - - - - 428

SANTEE, ELLIS M., Clean Milk, 299; Remarks, - - - - - 308
SEARLE, WILLIAM S., Remarks, 240, 251, 269; State Boards of Examiners in Medicine; Their Past, Present and Future, - 344
Scientific Program, - - - - - - - 26, 179
SEWARD, FREDERICK W., JR., Remarks, 106, 107; The Unfortunate Borderlander, - - - - - - - - 103
SEWARD, J. PERRY, Remarks, - - - - - - - 297
SCHENCK, HERBERT DANA, Address of the President, 162; Response for the Society, 161; Remarks, 159, 171, 203, 245; Natrum Muriaticum in Vernal Conjunctivitis, 275; Biographical Sketch, - 429
SHEPARD, GEORGE A., Remarks, - - - - - 149, 158, 237
SHREWSBURY, W. J., Cancer, 399; Remarks, - - - - 409
Shock and its Treatment, L. Luis Hartman, - - - - - 127
SIMONSON, J. T., Dietetic Methods in the Nutritional and Gastro-Intestinal Diseases of Infancy and Early Childhood, - - 64
SMITH, T. FRANKLIN, Remarks, - - - - - - 313
Special Legislative Fund, Report upon, - - - - - 171
Splenic Leukæmia, W. H. Doane, - - - - - - 146
Spinal Curvature, with Special Reference to Nebels' Suspension Frame and Sciatica, George Parker Holden, - - - - - 182
State Medical Examiners, Election of, - - - - - 22
Staphysagria in Chalazion, John B. Garrison, - - - - - 270
State Boards of Examiners in Medicine; Their Past, Present and Future, William S. Searle, - - - - - - 344
Standing Resolutions, - - - - - - - - - 471
State Directory, - - - - - - - - - 486
STEARNS, GUY B., Observations on the Homeopathic Therapeutics of Tuberculosis, 86; Remarks, 269; Kali Bromide in a Case of Climacteric Insanity, - - - - - - - - - 272
Surgery and the Public, William Francis Honan, - - - 394
SUTHERLAND, JOHN P., Why Do We Eat? What Should We Eat? 33
Surgery, Bureau of, - - - - - - - - 110, 364
The Backache of Endocervicitis, Homer I. Ostrom, - - - 133
The Control of Cases of Addiction, John T. Greenleaf, - - 107
The Diaphragm as a Barrier to Infection, J. Herbert Irish, - - 112
The Clinical Significance of Ciliary Neuralgia, Frederic G. Ritchie, - 220
Two Cases of General Paresis of Long Duration, Roy E. Mitchell, 327
The Future of Homeopathy—a Toast, DeWitt G. Wilcox, - - 458
The General Practitioner and His Insane Patients, Reeve Turner, - 333
The Homeopathic Treatment of Mental Diseases, William M. Butler, 337
The Influence of Homeopathy upon General Medicine—a Toast, John E. Wilson, - - - - - - - - - 455
The Pioneers—a Toast, Stuart Close, - - - - - 443
The Relation of the Family Physician to the Health Officer, Hills Cole, 309
The Results of Ventro-Suspension, A. R. Grant, - - - - 138
The Results of Some Uterine Infections, Wm. Francis Honan, - 139
The Nasal Sinuses as Routes for Infecting the Mastoid and Meninges, Ralph I. Lloyd, - - - - - - - - 235
The Tuberculosis Problem in the Hospital for the Insane, Roy E. Mitchell, - - - - - - - - 28

The Solonaceæ, or Nightshade Family, E. Wilton Brown, - - 292
The Unfortunate Borderlander, Frederick W. Seward, Jr., - - 105
The Value of Leucocyte Counts in Surgical Cases, Warren C. Daly, - 373
TEETS, CHAS. E., Remarks, - - - - - - - 241, 245
Thuja and Hepar in Uterine Fibroids, W. W. Blackman, - - 248
Treasurer, Report of, Reeve B. Howland, - - - - - 174
Thyroidectomy, DeWitt G. Wilcox, - - - - - - 123
Treatment of Acute Infectious Diseases, William C. Goodno, - 46
Town Index, - - - - - - - - - 487
TURNER, REEVE, The General Practitioner and His Insane Patients, 333; Remarks, - - - - - - - - 323
Ultimate Results in the Operative Treatment of Carcinoma of the Pelvic Organs, DeWitt G. Wilcox, - - - - - 410
Various Resolutions Adopted, - - - - - - - 176
VON DER LUHE, AUGUSTUS, Remarks, - - - - 262, 267, 270
WALMSLEY, R. F., Minor Surgical Clinic, - - - - - 419
WALTON, CHARLES E., Hyoscin, Morphin and Cactin Anæsthesia, 387, 393
Why Do We Eat? What Should We Eat? John P. Sutherland, - 33
WILCOX, DEWITT G., Thyroidectomy, 123; Remarks, 132, 139, 145, 391; The Future of Homeopathy—a Toast, 458; Ultimate Results in the Operative Treatment of Carcinoma of the Pelvic Organs, - 410
WILCOX, SIDNEY F., Remarks, 321, 387; Popular Errors Regarding Nephroptosis, - - - - - - - - 379
WILSON, JOHN E., Remarks, 326, 336; Toast, "The Influence of Homeopathy upon General Medicine, - - - - - 455
WINCHELL, WALTER B., Lachesis in Purpura Hæmorrhagica and Peliosis Rheumatica, 267; Remarks, - - - - - - 269
WOODMAN, ROBERT C., General Paresis and the Family Physician, - 314
X-Ray and Electrical Clinic, William H. Price, - - - - - 422

3 9
57

~~RV 394C~~

3 9

57